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Secretariat

2 April 2015

Information circular*

To: Locally recruited staff members at designated duty stations away from Headquarters participating in the Medical Insurance Plan

From: The Controller

Subject: **Medical Insurance Plan for United Nations locally recruited staff at designated duty stations away from Headquarters effective 1 April 2015**

The purpose of the present circular is to provide information regarding the Medical Insurance Plan (also referred to as "MIP" or "the Plan") for United Nations locally recruited staff at designated duty stations away from Headquarters and to set out the enrolment procedure, contribution rates, schedule of benefits, claims procedure and other relevant information on the use of the Plan. This circular complements administrative instruction ST/AI/2015/3 (hereinafter referred to as the "MIP administrative instruction").

Annex I of the present circular provides definitions of various terms used in this document.

Enrolment procedures

1. Participation in MIP is mandatory for all locally recruited staff members holding an appointment in the General Service and National Officer categories who serve at a designated duty station away from one of the relevant headquarters locations.

2. Notwithstanding that participation in MIP is mandatory, a MIP enrolment form must be completed by the staff member in respect of his or her own participation within 31 days upon entry into duty with the Organization. The form is obtainable from the local human resources or administering office and the website of the United Nations Health and Life Insurance Section (www.un.org/insurance/forms). In duty stations where the benefits/insurance module of Umoja has been implemented, enrolment for the staff member will be automatic upon approval of a personnel action by the local human resources office. At the time of his or her enrolment, the staff member may also enrol any eligible family members to be covered under MIP.

* The present circular will be in effect until further notice.

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Please recycle

Please refer to the participation and eligibility rules contained in the MIP administrative instruction.

3. To enrol additional eligible family members (upon marriage, birth or adoption of a child) or to terminate coverage for covered family members (upon divorce or death), the staff member must complete an enrolment form within 31 days of the qualifying event and submit it to his or her local human resources office. Otherwise, such enrolment or termination will only be allowed during the annual campaign.

4. Separating staff members who are eligible for after-service health insurance must also complete a MIP enrolment form to signify their intention to continue participation in the Plan. This must be done by the separating staff member as part of the separation process. Provisions related to the after-service health insurance programme under MIP is outlined in section 7 of the MIP administrative instruction.

5. It is the responsibility of the staff member or retiree to inform the administering office within 31 days of changes in family coverage by completing a new enrolment form in order to ensure that new family members, if eligible, will be covered and to avoid paying contributions for family members who are no longer eligible.

6. In the case of a staff member married to another staff member, please refer to section 2 of the MIP administrative instruction, on participation and eligibility.

7. Information regarding staff, after-service participants and their eligible family members who are covered under MIP is transmitted to the third-party administrator at least once a month by the local human resources office through the provision of an electronic eligibility file. In the case of offices that have implemented the benefits/insurance module of Umoja, the electronic eligibility file is transmitted by Headquarters. This file is the basis on which the third-party administrator produces identification cards, issues letters of guarantees to hospitals and other medical facilities and processes claims for reimbursement.

Contribution by the subscriber

8. The cost of the MIP benefit is shared between the subscriber and the United Nations. The actual contribution to be paid by the subscriber is based on a percentage multiplied by the remuneration of an active or retired staff, or surviving family member as defined in sections 6 and 7 of the MIP administrative instruction. The percentage varies according to the number of insured family members based on the following categories:

(a) For one insured person (subscriber alone);

(b) For two insured persons (subscriber plus one eligible family member);

(c) For three, four or five insured persons (subscriber plus two to four eligible family members);

(d) For six or more insured persons (subscriber plus five or more eligible family members).

9. The percentage of contribution for each category of coverage is set forth in annex II to the present circular. The method and timing for collection of these contributions are described in sections 6 and 7 of the MIP administrative instruction.

Third-party administrator

10. The United Nations has contracted Cigna, a global health benefits company, as the third-party administrator of MIP. In this role, Cigna will be responsible for the following functions:

(a) Issuing insurance cards based on eligibility information from the United Nations;

(b) Reviewing requests and issuing letters of guarantees to medical providers in case of emergency and scheduled hospitalizations;

(c) Reviewing and adjudicating claims for reimbursements according to the rules set by the United Nations;

(d) Establishing a network of medical providers and negotiating direct billing arrangements and discounted prices;

(e) Responding to queries from Plan members by phone and e-mail;

(f) Developing communication and educational materials, including up-to-date member Plan document and online member portal;

(g) Reviewing appeals, complaints and grievances from Plan members;

(h) Detecting and investigating fraud and abuse of Plan benefits for referral to the United Nations.

11. Additional information on Cigna is available in annex III to the present circular.

Benefits

Reasonable and customary

12. MIP covers the benefits described below, subject to the stated limitations. Cigna, as third-party administrator, is authorized by the United Nations to reimburse claims in line with these benefits on the basis of reasonable and customary charges applicable at the duty station. Reasonable and customary refers to the prevailing pattern of charges for professional and other health services at the duty station where the service is provided as reasonably determined by the third-party administrator.

13. In the case of expenses incurred during official mission travel for emergency medical care only, approved medical evacuation in the authorized location or medical care received in an approved regional area of care,[1] the expenses will be settled in accordance with the reasonable and customary cost level of the area or country where care was provided.

14. Any expenses incurred outside the country of duty station except those described in paragraph 13 above will be adjusted to reflect the reasonable and customary cost level of the duty station where the staff member is assigned, unless the reasonable and customary costs of the area or country where care is provided is

[1] Please see annex IV of this circular for the approved list of regional areas of care. This list is reviewed and updated on a regular basis in conjunction with the United Nations Medical Services Division, the United Nations Health and Life Insurance Section and the third-party administrator.

lower than that of the staff member's duty station. In case a reasonable and customary rate for the service is not available at the duty station, a ratio will be applied in reimbursing the expense that will be based on the higher of: (a) the cost of general medical treatment (that is, consultations) in the country of duty station compared to the country where service was received; or (b) the MIP reference salary expressed in United States dollars of the duty station compared to that of the country where service was received. The third-party administrator may also consult with its local medical correspondent, other providers in the country of duty station or local United Nations medical doctor, as necessary.

Hospital expenses (inpatient basis)

15. Reimbursement at 100 per cent is provided for hospital services and supplies provided during hospitalization (that is, inpatient), including services provided by a qualified physician, bed and board (semi-private accommodations), operating room, recovery room, intensive care and general hospital nursing care, as well as drugs and medicines administered in the hospital. Where hospital accommodation is provided at rates for a private room with only one bed, the reimbursement will be 70 per cent of the costs of bed and board and general nursing care at the private rate or 100 per cent of the rate for semi-private accommodation, whichever is greater. Pre-certification should be sought for all planned or scheduled hospital visits.

16. Reimbursement at 80 per cent is provided for the bed of an accompanying adult during a hospitalization of a Plan member under the age of 13 or if required by local legislation.

Professional services, devices and medications

17. Except for those listed in paragraph 18 below, the following services are reimbursed at 80 per cent for all Plan participants:

(a) Services provided by a qualified physician on an ambulatory or outpatient basis, including surgeon's fees (for example, for pre- and post-operation consultation, surgeries performed on an outpatient basis) and other medical services whether provided in a hospital, clinic or medical facility;

(b) Obstetrical services, including midwifery, provided by a licensed medical practitioner outside of the hospital;

(c) Laboratory tests and X-rays performed outside of the hospital;

(d) Drugs and medicines, recognized as such by the local health authorities, prescribed according to a diagnosis by a qualified physician as being necessary for the treatment of a specific medical condition;[2]

(e) Yearly routine eye examinations up to a $100 limit;

(f) Annual physical examinations for adults aged 20 and over;

(g) Six routine visits per year for children aged 0 to 1 year old, two visits per year for children aged 2 to 3 years old and one visit per year for children aged 4 to 19 years old;

[2] Non-reimbursable pharmacy items are included in the list of reimbursable and non-reimbursable expenses under MIP, available on the United Nations Health and Life Insurance Section and Cigna websites.

(h) Self-monitoring devices for diabetes;

(i) Contraceptives, including the contraceptive devices deemed medically necessary, with the exception of condoms;

(j) Physical therapy as prescribed by a physician. The prescription must specify the number of sessions and the actual length of treatment. If this period exceeds six months, the treating physician must reassess the treatment after six months and issue a new prescription. Treatments requiring more than 60 sessions per calendar year are subject to the prior authorization of Cigna's medical doctor/consultant.

18. The following services are reimbursed at 100 per cent for all Plan participants:

(a) Chemotherapy and radiation treatments outside of the hospital;

(b) Two voluntary HIV/AIDS blood tests and related test counselling per year;

(c) Immunizations for adults and children recommended by the local health authorities and/or the World Health Organization.

Mental, nervous and substance abuse care

19. Inpatient psychiatric care for mental and nervous disorders, including alcohol and substance abuse, is reimbursed on the same basis as inpatient hospital expenses. There is a 90-day limit on the length of stay in a treatment facility.

20. Outpatient psychiatric care for mental and nervous disorders, including alcohol and substance abuse, is reimbursed at the 80 per cent rate, subject to a limit (per eligible patient) in any calendar year of one MIP reference salary. This limit may, however, be waived for active staff members upon request from the United Nations Medical Director or the Chief Medical Officer in the duty station.

21. Services must be provided by a licensed psychiatrist, psychoanalyst, psychologist or psychiatric social worker. Inpatient care for alcohol and substance abuse must be carried out at a facility certified for detoxification and rehabilitation.

Optical lenses and hearing aids

22. In order to be entitled to these benefits, a subscriber or eligible family member must have been enrolled in the MIP scheme for one year or more:

(a) *Optical or contact lenses*: subject to the one-year waiting period, reimbursement is made at the 80 per cent rate with a maximum of $75 per lens and a maximum of two lenses in a 12-month period (per eligible patient), provided there is a change in the lens prescription (see example 1 in annex V to the present circular);

(b) *Eyegiass frames*: subject to the one-year waiting period, reimbursement is made at the 80 per cent rate with a maximum of $50 per frame and a maximum of one frame in a 24-month period (per eligible patient);

(c) *Hearing aids*: subject to the one-year waiting period, reimbursement is made at the 80 per cent rate with a maximum of $300 per apparatus, including the related examination, and a maximum of one apparatus per ear in a period of three calendar years (per eligible patient);

(d) *Laser eye surgery*: reimbursement is made at the 80 per cent rate up to a maximum of $150 per eye subject to prior authorization and submission of a medical report.

Dental care

23. Reimbursement at the 80 per cent rate is provided for dental services, including:

(a) Prophylaxes (tooth cleaning), up to two visits per calendar year;

(b) Preventive and routine care, false teeth, crowns, bridges, implants, other similar appliances;

(c) Dento-facial orthodontics (for example, braces), if treatment is started before the patient is 15 years of age (except in the case of an accident); treatment period up to 4 years.

24. The general provision regarding reasonable and customary charges under paragraphs 12 to 14 of the present circular applies to dental expenses as well. For instance, a charge for a gold tooth or gold filling would be considered unreasonable when less expensive services are available for the same condition.

25. The maximum benefit for dental care is subject to a limit in any calendar year (for each eligible patient) equivalent to one half of the MIP reference salary (see example 2 in annex V to the present circular). In case of an accident, the dental care limit for each eligible patient will be equivalent to the MIP reference salary, provided that treatment is undertaken within 12 months of the date of the accident and subject to prior authorization.

Exclusions

26. The following will not be reimbursed under the Plan:

(a) Spa cures, rejuvenation cures, cosmetic treatment;

(b) Consequences of a voluntary or intentional act committed by the beneficiary, for example, a brawl, except in the case of self-defence;

(c) Motor-vehicle racing or dangerous competitions in respect of which betting is allowed (normal sports competitions are covered);

(d) Any portion of the expenses for medical services and supplies that exceeds the regular and customary charge for the services or supplies;

(e) Home help, family help or similar household assistance, and fees of persons who are not qualified nurses;

(f) Any charges for services or supplies that have not been prescribed or approved by a physician;

(g) Hospital charges for telephone, television or persons other than the patient;

(h) Infertility treatments;

(i) Any voluntary surgeries that are not done for medical reasons (for example, elective plastic surgery);

(j) Food and dietary products (other than those normally provided during hospitalization), cosmetics and toilet articles;

(k) Expenses for travel and accommodations except for charges for a professional ambulance service used to transport the insured participant between the place where he or she is injured by an accident or stricken by disease and the first hospital where the treatment is given;

(l) Self-testing devices, except for diabetes.

27. In case of doubt with respect to the meaning of any of the above exclusions or coverage of items not listed above, the relevant headquarters should be consulted.

Detailed list of reimbursable and non-reimbursable expenses

28. A detailed list of reimbursable and non-reimbursable treatments, services and expenses under MIP can be found in annex VI to the present circular.

Maximum reimbursement of expenses

29. Reimbursement of expenses at the rates described above will be allowed in respect of any subscriber or enrolled family member up to a limit in any calendar year equivalent to six times the MIP reference salary in effect on 1 January and converted to United States dollars at the United Nations operational rate of exchange. In case of a secondary salary scale introduced in the duty station, the scale to be used is the one that results in a higher MIP reference salary.

Stop loss provision

30. Once a subscriber, along with his or her enrolled family members, incurs collectively out-of-pocket expenses (that is, the 20 per cent of the reasonable and customary charges that is not covered by the Plan) up to the level of one half of his or her monthly net base salary (that is, gross salary less staff assessment), the Plan will commence reimbursement of an additional 80 per cent on the residual; that is, that portion of reasonable and customary expenses not reimbursed. For purposes of the application of the stop loss provision, out-of-pocket expenses shall include all covered professional expenses, devices and medications, but will exclude dental, mental and nervous care, vision and hearing expenses. The annual MIP entitlement limit described in paragraph 29 above does not have to be met in order to trigger the stop loss provisions.

31. In the case of a retiree, the stop loss provision will be triggered when his or her out-of-pocket expenses total one half of the remuneration basis for calculating his or her contribution (that is, 25 per cent of the monthly net base salary at the date of separation adjusted by the global cost-of-living increases declared by the United Nations Joint Staff Pension Fund).

Hardship provision

32. The hardship provision shall be applicable in the event of major medical expenses where the subscriber or an enrolled family member is faced with expenses that are so significantly over and above the normal limits payable under the Plan that they would cause undue financial hardship. Undue financial hardship will not be considered as long as the total annual out-of-pocket expenses incurred by the

subscriber and enrolled family members for the reasonable and customary care have not exceeded one half of the subscriber's monthly net base salary for active staff members or one fourth of the monthly net base salary at the date of separation adjusted by the global cost-of-living increases declared by the United Nations Joint Staff Pension Fund for retirees.

33. The unreimbursed portions in respect of dental, vision and hearing care shall not be taken into account in determining hardship; neither shall any expenses for medical and hospital services that are not considered recognized expenses (that is, expenses in excess of reasonable and customary charges). For instance, the difference between semi-private and private accommodation in the hospital would not be taken into account.

34. The out-of-pocket expenses for all enrolled members of the subscriber's family will be taken into account for the purpose of hardship.

35. The third-party administrator will be responsible for submitting directly to the United Nations Health and Life Insurance Section any hardship cases for approval, and no action is required from the subscriber to benefit from this provision.

Coordination of benefits

36. The Plan does not reimburse costs for services that have been or are expected to be reimbursed under another insurance, social security or similar arrangement (Government or private). The participant is therefore required to first claim under that applicable arrangement and then to submit a claim under MIP only for any unreimbursed amount. The financial benefit for the participant is illustrated in example 3 of annex V to the present circular.

37. For purposes of coordination of benefits, MIP will be considered primary in the following instances:

(a) The Plan member is the subscriber or the primary person insured under the Plan;

(b) The other insurance stipulates that it is secondary.

MIP as primary insurance may not apply in case a member is covered under a social security or required Government scheme.

Claims procedure and reimbursement

When and where to submit

38. The United Nations has contracted Cigna as the third-party administrator to review and process claims under MIP. When a subscriber or eligible family member has incurred expenses for services reimbursable under MIP, the subscriber should submit a claim under the Plan to Cigna as soon as possible after treatment or care has been provided, normally within 60 days. Claims not presented by the subscriber within 12 months after the expenses have been incurred shall be denied. Several small claims for the same patient may be grouped and submitted at one time.

Forms and supporting documentation

39. The subscriber should complete, sign and submit the Cigna MIP claim form, copies of which are available from the local human resources office or the member

portal of Cigna (see annex III to the present circular). Signing the claim form signifies the subscriber's certification of the truth and accuracy of the information provided. The subscriber will be held responsible for any false or incorrect information submitted in accordance with the Forfeiture and Suspension of Benefits section of the MIP administrative instruction.

40. In addition to the MIP claim form, the subscriber must submit proper supporting documentation consisting of:

(a) Original bills or receipts of payment showing the name of the patient, diagnosis and the nature, dates and detailed costs of the services or treatments rendered. In case of hospitalization, a medical report indicating the diagnosis completed by the doctor must be submitted. This medical report must also include the admission and discharge dates. If the Government/local authorities in the country have additional requirements regarding receipts for services, these must be fulfilled in respect of the claims submitted under MIP. Receipts with lump sum amounts only will not be accepted;

(b) Original prescriptions and original detailed receipts for drugs and medicines; laboratory, X-rays and imaging tests; optical lenses; and hearing aids, including details on the diagnosis. Receipts with lump sum amounts will not be accepted;

(c) Copies of prescriptions may be accepted for chronic diseases only, for example, diabetes, to be renewed every six months or when local authorities require the original prescription to be kept by the pharmacy.

Screening of claims

41. Cigna is responsible for screening and monitoring the completeness and correctness of each claim and for ensuring that it conforms to the requirements of the present rules and is consistent with reasonable and customary costs as described in paragraphs 12 to 14 above. It may request additional documentation or seek advice from any source in respect of any claim that appears unreasonable or questionable, whether in terms of the institution or professional services concerned, the nature or the treatment of the illness or the costs incurred. Staff members shall fully cooperate with such requests, and failure to do so will result in the denial of reimbursement of the claim.

Referral to the relevant headquarters

42. Cigna has the authority to settle medical claims under MIP. At its discretion, claims may be referred to the Insurance and Disbursement Service at Headquarters for advice. Guidance may also be sought in case of doubt as to the interpretation of the rules.

43. While the third-party administrator is authorized to settle claims up to the annual MIP ceiling, claims exceeding the six-month MIP reference salary threshold will be reported to the Insurance and Disbursement Service at Headquarters on a periodic basis for approval under the hardship provision, if applicable.

Appeals and disputes

44. Claims questions must be addressed directly to Cigna. In the case of disputed claims, subscribers must follow the appeals process described in Cigna's MIP benefit description document available on the member portal. The subscriber must exhaust the appeals process with Cigna before requesting assistance from the Health and Life Insurance Section at Headquarters.

45. Only appeals of the final determination of Cigna that specifically state a manifest error made by Cigna in the application of the terms and conditions of the Plan will be considered. Consequently, appeals that simply disagree with the final determination of Cigna or contest the coverage of the Plan will not be considered.

46. Appeals that meet the above criteria can be sent to the Health and Life Insurance Section and must include the following documentation:

(a) The subscriber's request for exceptional reimbursement;

(b) Detailed explanation of the case;

(c) Copies of Explanation of Benefits denying reimbursement;

(d) Copies of all appeal letters sent by the subscriber to Cigna;

(e) Copies of all responses received by the subscriber from Cigna;

(f) Documentation from the medical provider that reflects diagnosis, prognosis, justification for the services or treatment provided and cost of the medical services or treatment required.

47. All medical information will be referred to the Medical Services Division for its review and recommendation on the medical necessity of the treatment. Upon receipt of the recommendation, the Health and Life Insurance Section will advise the subscriber. If the exceptional reimbursement is approved, the Health and Life Insurance Section will advise Cigna to take the necessary reimbursement action.

After-service health insurance

48. After-service health insurance is available under the conditions described in section 7 of the MIP administrative instruction. Contribution rates are shown in annex II to the present circular. The schedule of benefits for retirees covered under after-service health insurance is the same as that for active staff.

Annex I

Definitions

The following definitions are intended to clarify the meaning of certain terms that are used throughout the present circular:

Accident: The sudden action of an external force causing impairment of physical integrity.

Administering office: The office that has the responsibility for the day-to-day operation of the Plan (for example, enrolment, collection of contributions from active and former staff members, premium accounting) at a given duty station.

After-service participant: Retirees, participating survivors and recipients of a periodic disability benefit from the United Nations Joint Staff Pension Fund and/or appendix D.

Annual campaign: Period during the year when a subscriber can enrol or terminate coverage for eligible family members after the original 31-day period following a qualifying event; the annual campaign takes place during a set period every year with the effective date of coverage being the first of July.

Co-insurance: A subscriber's share of the cost of a covered health-care service or expense that is usually calculated as a percentage of the allowed amount for a service. For example, if the Plan covers 80 per cent of the reasonable and customary cost of a service, the co-insurance is 20 per cent or the share that the subscriber is responsible for.

Coordination of benefits: The settlement of reimbursable medical expenses where more than one medical insurance scheme covers a subscriber and/or his or her eligible family members; the instances when MIP is considered the primary plan are described in paragraphs 34 and 35 above.

Dental services: Services performed by a dental practitioner or a dentist who is licensed to practise dentistry in the country in which he or she practises the profession.

Diagnosis: The identification by a licensed physician of an illness or nature of a disease.

Eligibility file: A file that is sent electronically on a monthly basis by the local human resources office or by Headquarters (in case the Umoja benefit module has been implemented in the duty station) to the third-party administrator that contains information on all active or retired staff members and their eligible family members who are covered under the Plan; this file is the basis on which the third-party administrator determines who is eligible for coverage under MIP.

Eligible family members: A subscriber's recognized spouse and one or more dependent children, as defined in staff rule 3.6 (a) (iii). MIP recognizes only one eligible spouse. A subscriber's children who meet the criteria for a dependent child under staff rule 3.6 (a) (iii), but for whom the staff member does not receive a dependency allowance owing to local limits on the number of children for whom a dependency allowance is payable, may also be considered as an eligible family member for the purpose of enrolment in the Plan. In the case of an after-service subscriber, eligible family members are defined as the spouse and children already

enrolled at the time of separation from service and any child born within 300 days of separation. A staff member's parents, brothers and sisters, whether or not recognized as secondary dependants, are not eligible for the Plan.

Eligible former staff member: A former staff member who meets the eligibility criteria for after-service health insurance as set out in section 7 of the MIP administrative instruction.

Emergency medical care: Medical treatments that are undertaken owing to an unplanned, sudden and acute illness or injury and which, for medical reasons, cannot be delayed or postponed.

Enrolled family member: An eligible family member who is enrolled in MIP.

Explanation of Benefits: A statement that is sent to a subscriber by the third-party administrator that shows medical expenses claimed, reimbursement by the Plan and any balances that are the responsibility of the subscriber. It may be sent by mail or electronic mail or as a downloadable document from the third-party administrator's website.

Hospital: An institution licensed by the Government to provide medical and surgical treatment and nursing care for sick or injured persons. Such care normally involves overnight stay (or inpatient care), thus requiring such facilities to have inpatient beds and continuous physician and nursing services under the supervision of licensed professionals. These facilities may also provide same-day treatments (outpatient care).

Inpatient care/treatment: Services provided to a person who has been admitted to a hospital and will stay one or more nights.

Medical information: Any information acquired by medical personnel, whether orally or in writing, relating to the physical or mental condition of any individual covered under the Plan. For purposes of the proper review and administration of claims, such information may include, but not be limited to, diagnosis, physician's medical reports, results of diagnostic tests, treatment plans, prescriptions, etc.

Medical necessity (or medically necessary): All health-care services (that is, procedures, treatments, supplies, devices, equipment, facilities or drugs) that a medical practitioner, exercising prudent clinical judgement, would provide to a covered individual for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that are: (i) in accordance with generally accepted standards of medical practice; (ii) clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the covered individual's illness, injury or disease; (iii) not primarily for the convenience of the covered individual, physician or other health-care provider; and (iv) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that covered individual's illness, injury or disease.

Medical net salary: A staff member's remuneration that is used as the basis for calculating his or her MIP contributions. It consists of gross salary less staff assessment plus any language and non-resident's allowance. The remuneration is that which appears on the salary scale for the month in question at the grade and step of the staff member, including temporary grade and special post allowance.

MIP reference salary: The monthly net base salary at the top step of the highest regular General Service level of the duty station scale. For this purpose, any Extended General Service or National Professional Officer levels are not taken into account, nor are longevity or long-service steps. The MIP reference salary is based on the scale in use on 1 January each year and is not revised on the basis of subsequent salary scale revisions unless such revisions have a retroactive effective date prior to the reference date. In the case when a grandfathered salary scale is introduced in the duty station, the scale to be used is the one that results in a higher MIP reference salary.

Out-of-pocket amount or expenses: The unreimbursed portion of recognized medical expenses (or co-insurance) that are taken into account in determining the application of the hardship provisions.

Outpatient care/procedures: Services provided to a person in a clinic, emergency room, hospital, medical or surgery centre or other facilities that does not involve an overnight stay in the facility. The patient receives care during the day and returns home.

Participating survivor: An eligible family member who survives a subscriber.

Physician: A person who is licensed to practise medicine by the authorities responsible for the territory in which he or she is practising.

Prognosis: A description of the likely course of a disease or illness provided by a physician, including the patient's chances for recovery.

Regional area of care: A country or region of a country generally neighbouring the duty station of the subscriber and enrolled family members that is specially designated by the United Nations where they can undergo medical treatment without the need for an approved medical evacuation. A regional area of care is designated solely owing to the lack of adequate facilities in the duty station or the country of the duty station. Medical expenses incurred in such areas will be reimbursed at the reasonable and customary rate of the designated location.

Reasonable and customary: The prevailing pattern of charges for professional and other health services at the staff member's duty station or the approved location (for example, the place of approved medical evacuation or regional area of care) where the service is provided.

Recognized expenses: The expenses for services claimed, provided they are found to be reasonable and customary at the duty station or, when obtained elsewhere in the country or at an approved medical evacuation location or regional area of care, at the place provided. If the expenses claimed are found to be above what is considered reasonable and customary, then the recognized amount for the purpose of calculating reimbursement is the reasonable and customary amount as reasonably determined by the third-party administrator.

Subscriber: An active or after-service participant enrolled in MIP or, upon the death of the former or the latter, the surviving spouse (if any) or the eldest eligible child.

Third-party administrator: An outside entity engaged by the United Nations for the processing and payment of MIP claims.

Annex II

Contributions and total premium effective 1 September 2015 (expressed as a percentage of applicable net salary)*

Category of coverage	*Subscriber's contributions*	*Organization's contributions*	*Total premium*
A. Full-time and former staff			
For one insured person (subscriber alone)	1.05	3.15	4.20
For two insured persons (subscriber plus one eligible family member)	1.35	3.95	5.30
For three to five insured persons (subscriber plus two to four eligible family members)	1.85	7.35	9.20
For six or more insured persons (subscriber plus five or more family members)	2.40	9.55	11.95
B. Staff on special leave without pay			
For one insured person	4.20	0.00	4.20
For two insured persons	5.30	0.00	5.30
For three to five insured persons	9.20	0.00	9.20
For six or more insured persons	11.95	0.00	11.95
C. Staff on special leave with half/partial pay			
For one insured person	2.62	1.58	4.20
For two insured persons	3.32	1.98	5.30
For three to five insured persons	5.52	3.68	9.20
For six or more insured persons	7.17	4.78	11.95

* As explained in section 7 of the MIP administrative instruction, on after-service health insurance, the level of remuneration used is adjusted in order to calculate the contributions of former staff members and their eligible survivors.

Annex III

Third-party administrator of the Medical Insurance Plan

Cigna

Detailed information on the Plan is available to subscribers in the Cigna MIP plan description document available in the Health and Life Insurance Section (www.un.org/insurance/circulars) and the Cigna website (www.cignahealthbenefits.com).

Cigna can be reached 24 hours daily, 7 days weekly, 365 days annually. In case of emergency or if you simply have a question, you can contact the Cigna multilingual staff in several ways. The contact details are also mentioned on your personal web pages and on your membership card.

Your region	*Europe, Commonwealth of Independent States, Middle East and Algeria, Egypt, Libya, Morocco, Tunisia and Western Sahara*	*Sub-Saharan Africa, that is all of Africa* ***except for Algeria, Egypt, Libya, Morocco, Tunisia and Western Sahara***	*Asia-Pacific*	*Latin America and the Caribbean*
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Toll-free number

Whenever feasible, you can call Cigna for free through a toll-free number. If there is no toll-free number available for your country of stay, you can use the United Nations-dedicated phone number, which is also mentioned on your membership card. You can find the full list of available toll-free numbers per country on your personal web page.

Personal web page

Subscribers are strongly encouraged to create their personal account on the Cigna website by establishing a username and password. Once logged in, the subscriber and his or her covered family members can obtain information on the status of their claims, view benefit documents, request identification cards and print temporary identification cards, among other items.

Instructions on how to log onto the website with a temporary password will be sent by e-mail by Cigna if a subscriber's e-mail address is provided in the eligibility file submitted on a monthly basis by the local human resources office. Otherwise, subscribers will receive a letter containing such instructions.

Detailed instructions and frequently asked questions about logging onto the Cigna web pages are available at www.cignahealthbenefits.com.

Annex IV

Approved regional areas of care

Following are the approved regional areas of care effective 1 April 2015.

Country of duty station	*Regional area of care*
Afghanistan	Pakistan and India
Bhutan	India
Central African Republic	Cameroon
Democratic Republic of the Congo (for MIP members residing near the eastern border of the country)	Burundi, Rwanda and Uganda
East Timor	Australia (Darwin only)
Guinea-Bissau	Senegal
Haiti	Dominican Republic
Iraq	Jordan
Kosovo	Albania, Bosnia, Croatia, Macedonia, Montenegro, Serbia, Slovenia
Lao People's Democratic Republic	Thailand (Nong Khai and Udon Thani provinces)
	Expenses incurred at the Bumrungrad Hospital will be strictly reimbursed on the basis of reasonable and customary limits applicable in Thailand. Please note that MIP participants will be responsible for all charges exceeding the reasonable and customary limits applicable in Thailand.
Lesotho	South Africa
Liberia	Ghana
Mali	Senegal
Myanmar	Thailand
	Expenses incurred at the Bumrungrad Hospital will be strictly reimbursed on the basis of reasonable and customary limits applicable in Thailand. Please note that MIP participants will be responsible for all charges exceeding the reasonable and customary limits applicable in Thailand.
Sierra Leone	Ghana
Somalia	Kenya
South Sudan	Uganda
Sudan	Egypt
Swaziland	South Africa
Zimbabwe	South Africa

Annex V

Examples illustrating specific Medical Insurance Plan rules

The examples contained within this annex are intended to clarify specific rules of the Medical Insurance Plan and are for illustration only.

Example 1: Maximum reimbursement of expenses

In the duty station, G-7/step XV is the highest regular step on the General Service scale and the corresponding annual net salary is 24,500 Ethiopian birr. The MIP reference salary, as defined in administrative instruction ST/AI/2015/3, is 2,042 Ethiopian birr. The maximum reimbursement under MIP for any subscriber or enrolled family member is 12,252 birr per person per year, or six times the MIP reference salary.

Example 2: Application of the stop loss provision

In June 2014, Ms. Diallo required medical treatment that cost $4,075, which was a reasonable and customary cost for the duty station. MIP covered 80 per cent of the cost, while Ms. Diallo was responsible for the 20 per cent, equivalent to $815, which was counted towards her out-of-pocket expenses.

Ms. Diallo's monthly net base salary as a G-4/step IV is $1,630. Her out-of-pocket expenses to date of $815 are equivalent to half of her monthly net base salary.

In August 2014, Ms. Diallo needed another medical treatment that cost $500, which was a reasonable and customary cost for the duty station. She will be reimbursed $400, or 80 per cent of $500. For that expense, her out-of-pocket expense is $100.

Since Ms. Diallo's total out-of-pocket expenses before that treatment had already reached half of her monthly net base salary, she will be reimbursed an additional $80, or 80 per cent of the balance $100 that the Plan normally does not cover. Her total reimbursement for this treatment will therefore be $480 (that is, the usual $400 reimbursement plus $80 as a result of the application of the stop loss provision).

All other eligible expenses for the year will be paid with the additional reimbursement under the stop loss provision.

Example 3: Application of the hardship provision

Mr. Patel required medical treatment for a serious medical condition on an outpatient basis. The total cost for this series of treatment was 500,000 rupees, which is a reasonable and customary cost for the duty station.

Due to previous claims for hospitalization, outpatient doctor's fees and prescription medication, the expenses reimbursed by MIP to date for Mr. Patel total 800,000 rupees and his out-of-pocket expenses total 25,000 rupees.

The annual maximum reimbursement for the duty station is 891,600 rupees, which is six times the MIP reference salary. Mr. Patel's monthly net base salary is 56,840 rupees.

Of the expenses for this new treatment of 500,000 rupees, the Plan would normally reimburse 400,000 rupees (80 per cent) and Mr. Patel would have additional out-of-pocket expenses of 100,000 rupees.

Of the 400,000 rupees, the amount of 91,600 rupees would be applied against the remaining balance of the annual maximum reimbursement ceiling (that is, 891,600 rupees less the 800,000 rupees already paid by the Plan to date). The remaining 308,400 rupees will be applied under the hardship provision upon approval by United Nations Headquarters.

In addition, although Mr. Patel would normally be responsible for the 100,000 rupees out-of-pocket cost (or 20 per cent of the 500,000 rupee expense), since his out-of-pocket expenses to date already total 25,000 rupees, only 3,420 rupees of the 100,000 rupees will be his responsibility under the hardship provision. The balance of 96,580 rupees will be reimbursed by the Plan.

Total reimbursement by the Plan for this 500,000 rupee treatment will be 496,580 rupees (that is, 400,000 rupees plus the additional 96,580 rupees under the hardship provision).

Total reimbursement to date by the Plan will be 1,296,580 rupees (that is, 800,000 rupees already paid by the Plan before the new treatment plus the 496,580 rupee reimbursement processed under the hardship provision).

Total out-of-pocket expenses for Mr. Patel would be 28,420 rupees (that is, 25,000 rupees that he already paid before this new treatment plus the 3,420 rupees for the new treatment).

Since Mr. Patel has reached the half month net base salary ceiling for out-of-pocket expenses, and hardship has been approved for him, all of his subsequent eligible medical expenses for the year will be reimbursed by MIP at 100 per cent.

Example 4: Reasonable and customary reimbursement of claims

Mr. Uhuru consulted a doctor specializing in cardiology in his duty station and paid a consultation fee of 12,000 shillings. The prevailing cost for such consultations in his duty station is only 9,000 shillings. Mr. Uhuru will thus be reimbursed 7,200 shillings, or 80 per cent of a reasonable and customary cost of 9,000 shillings. He will be responsible for the balance of 4,800 shillings.

Three months later, Mr. Uhuru, while at a training course in South Africa, decided to have a crown made for his tooth by a local dentist. This cannot be considered as an emergency treatment. The work cost 4,000 rand or the equivalent of 35,000 shillings in the currency of his duty station. When he returned and submitted his claim, it was determined that the same work if done at the duty station would have cost 22,000 shillings only, which is less than the shilling equivalent of 4,000 rand. Mr. Uhuru will thus be reimbursed 17,600 shillings (80 per cent of 22,000) only.

Example 5: Vision benefits

Mr. Mbongo has been participating in MIP for more than one year. In September, he purchased an eyeglass frame for $75 and $80 for each of the two lenses, for a total cost of $235.

MIP reimbursed him the maximum of $50 for the frames, since 80 per cent of his $75 frame is $60, which is above the limit for eyeglass frames. The Plan also reimbursed $64 for each of the lenses (that is, 80 per cent of $80). His total reimbursement from MIP is $170. The balance of $65 (total cost of $235 less the $170 reimbursed by the Plan) is Mr. Mbongo's responsibility.

Example 6: Dental benefits

In a certain duty station, G-7/step IX is the highest step on the General Service scale (excluding longevity steps) and the corresponding annual net salary is 688,000 pesos. Thus the monthly net salary at the highest step is 57,333.30 pesos and the maximum benefit payable in a calendar year to any participant in the Plan for dental services in respect of one insured person is 28,666.65 pesos.

Example 7: Coordination of benefits

Ms. Khan was treated by a doctor for a mild ulcer, which did not require surgery. Her total bill came to 2,500 rupees, for which her national health scheme reimbursed her 1,500 rupees. The third-party administrator considered the bill for 2,500 rupees to be reasonable and customary and would have ordinarily reimbursed Ms. Khan 2,000 rupees (80 per cent of 2,500). Since Ms. Khan had received reimbursement of 1,500 rupees from the national health plan, she then submitted a request for reimbursement under MIP for the balance of 1,000 rupees. Given that the balance of 1,000 rupees was within the reasonable and customary limits, she received a reimbursement of 800 rupees (80 per cent of 1,000). As a result, her combined reimbursement amounted to 2,300 rupees.

Ms. Khan's total bill was therefore reimbursed at a higher level since she claimed under the two medical insurance coverages available to her — the national health scheme and MIP.

Example 8: Contributions by a retired subscriber

Mrs. Nantakarn retired from the Organization at age 62 in 2010 at the G-5/step IX level. At that time, her monthly net salary was 118,500 baht. She now participates with her husband in the after-service coverage of MIP. Her current monthly contribution to MIP would be determined by taking 50 per cent of the 118,500 baht salary adjusted by the global cost-of-living increases declared by the United Nations Joint Staff Pension Fund (2.9 per cent for 2011, 2.0 per cent for 2012 and 3.0 per cent for 2013) and multiplying by the contribution rate for two-person coverage of 1.40 per cent.

Therefore: 118,500 baht x 50 per cent x 1.029 x 1.02 x 1.03 x 1.40 per cent =
897 baht (rounded).

Her total quarterly contribution would be 2,691 baht, or 897 baht multiplied by 3 months.

Example 8: Contributions of a retired staff member lacking the required 10 years of participation in MIP for subsidy

Mr. Buendia joined the Organization on 1 October 2004 and retired on 31 December 2012 at age 62, having completed 8 years and 3 months of participation in MIP. Prior to that, he participated for one year in a qualifying

medical scheme of another United Nations organization. Upon retirement, he therefore had a total of 9 years and 3 months of qualifying participation, which is nine months short of the 10-year participation required for a subsidy. He will therefore have to pay the full premium (subscriber plus the Organization's portions) for the first three quarters of his after-service coverage untii he completes the 10 years of qualifying coverage. Thereafter, he will receive the applicable subsidy from the Organization.

Example 9: Contributions of a retired subscriber and surviving spouse

Mrs. Perez retired from the United Nations at age 55 with more than 10 years of MIP participation. She joined the MIP after-service plan with her husband and son. At the time of her retirement she had been at the G-6/step X level, receiving a net monthly salary of 40,000 pesos. There were no cost-of-living adjustments declared by the United Nations Joint Staff Pension Fund after her retirement. The subscriber contribution for coverage of three persons is 1.90 per cent. Her contribution is calculated as follows:

40,000 pesos x 50 per cent x 1.90 per cent = 380 pesos or 1,140 pesos per quarter

Two years later, Mrs. Perez died. At the time of her death, she had been paying 380 pesos as her monthly contribution since there were no cost-of-living adjustments declared by the Pension Fund.

One month after the death of his wife, Mr. Perez visited the United Nations office to confirm his and his son's participation in MIP. The administrative officer informed Mr. Perez that his monthly contribution would now be reduced because the contribution of the surviving spouse and children will be one half that of the former staff member through whom they were previously insured (or 25 per cent of the monthly net salary of the former staff member at the time of retirement adjusted in accordance with paragraph 7.17 of the MIP administrative instruction). In addition, their coverage will change from three persons to two persons only and the contribution rate will change to 1.40 per cent. Mr. Perez's contribution will therefore be calculated as follows:

40,000 pesos x 25 per cent x 1.40 per cent = 140 pesos or 420 pesos per quarter

The following year, the United Nations Joint Staff Pension Fund declared a cost-of-living adjustment of 3.0 per cent. The new contribution would be calculated as follows:

40,000 pesos x 25 per cent x 1.03 x 1.40 per cent = 144 pesos (rounded)

The United Nations office will inform Mr. Perez that the monthly contribution will increase to 144 pesos, or 432 pesos per quarter.

Example 10: Medical evacuation

As a result of a life-threatening medical condition that could not be treated at his duty station, Mr. Ahmed's son was approved by the United Nations Medical Service for medical evacuation to Amman, Jordan, which is the nearest recognized regional medical centre according to information circular ST/IC/2000/70.

Because it was a medical evacuation, all hospitalization expenses will be settled by MIP based on reasonable and customary costs of Amman and not the duty station.

However, Mr. Ahmed elected to bring his son to Beirut, despite the approval for evacuation to Amman. All hospitalization expenses will be settled by MIP based on the reasonable and customary costs of Amman, the approved location, and not Beirut. Any expenses in excess of the costs of Amman will be borne by Mr. Ahmed.

Example 11: Regional area of care

Mr. Ali, a local staff member in Somalia, required medical treatment that is not available at his duty station. His condition does not qualify him for a medical evacuation approved by the Organization.

However, Kenya has been designated as a regional area of care for Somalia. Mr. Ali can therefore seek care in Kenya without approval from the Organization. His medical expenses in Kenya will be reimbursed based on reasonable and customary charges in that location and not his duty station. Travel expenses to Kenya will be the responsibility of Mr. Ali and cannot be reimbursed by the Plan.

If Mr. Ali opts to go to the United Arab Emirates instead of Kenya, his expenses there will be reimbursed based on reasonable and customary charges of his duty station since the United Arab Emirates is not an approved regional area of care for Somalia.

Annex VI

List of reimbursable and non-reimbursable expenses under the United Nations Medical Insurance Plan[a]

Effective 1 April 2015

All reimbursable expenses must be medically necessary to the patient's condition and subject to reasonable and customary charges, in accordance with paragraphs 12 to 14 of the present circular, and to the usual limitations and exclusions of the Plan.

Expense type	Is it reimbursable?
Acne treatment	Reimbursable, subject to the limitations and exclusions of the Plan. See dermatology.
Acupuncture	Reimbursable at the rate of 80 per cent for chronic pain syndrome treatment only, provided: (a) Treatment is recognized as a valid treatment modality by the competent health authorities of the country; (b) Treatment is rendered by a qualified medical doctor or licensed acupuncturist. Attending physician's prescription must specify: (a) Type of treatment to be rendered; (b) Number of sessions; (c) Actual length of treatment. If the duration of the treatment exceeds three months, the attending physician must reassess the treatment and issue a new prescription. See alternative medicine. Covered diagnoses for treatment by acupuncture include: tension headache, migraine headache, psychalgia, neuralgia, backache, lumbago, muscle spasm and bursitis. Acupuncture treatment in lieu of anaesthesia is also reimbursable.
Addictionology	Reimbursable, subject to the limitations and exclusions of the Plan. See substance abuse.
Adolescent medicine	Reimbursable, subject to the limitations and exclusions of the Plan.

[a] If a treatment, service or item is not listed and there are doubts about the coverage, the subscriber should contact Cigna for guidance.

Expense type		Is it reimbursable?
AIDS medication		Reimbursable, subject to the limitations and exclusions of the Plan. See drugs.
Air conditioners		Non-reimbursable.
Air purifiers		Non-reimbursable.
Alcohol treatment		Reimbursable, subject to the limitations and exclusions of the Plan. See substance abuse.
Allergy testing and treatment		Reimbursable at the rate of 80 per cent.
Alternative medicine		Normally non-reimbursable. Only certain treatments/ therapies included in this document are reimbursable at the rate of 80 per cent provided: (a) There is a medical condition that requires treatment; (b) Treatment is rendered by a qualified medical doctor in the country where the treatment is rendered; (c) Treatment is recognized as a valid treatment modality by the competent health authorities of the country in the country of treatment. If there is a treatment/therapy not included in this document and there are doubts about whether it is reimbursable, please check with Cigna.
Alveolectomy		See oral surgery.
Ambulance	Surface	Reimbursable at the rate of 80 per cent provided professional ambulance service is to transport a person from the place where he/she is injured or stricken by disease to the first hospital where treatment is given.
	Air	Non-reimbursable under MIP. See provisions for medical evacuations in administrative instruction ST/AI/2000/10 and information circular ST/IC/2000/70 on medical evacuation.
Amniocentesis		Reimbursable at the rate of 80 per cent.
Anaesthesiology		Reimbursable, subject to the limitations and exclusions of the Plan. See hospital services and supplies.
Antiretroviral drugs		Reimbursable, subject to the limitations and exclusions of the Plan. See drugs.
Apicoectomy		See endodontics.

Expense type		Is it reimbursable?
Appetite suppressants		Normally non-reimbursable. Only reimbursable for morbid obesity where the prescription of appetite suppressants is medically necessary and appropriate. Attending physician's prescription must specify the length of treatment. If the duration of the treatment exceeds three months, the attending physician must reassess the treatment and issue a new prescription.
Applied kinesiology		Non-reimbursable. See alternative medicine.
Aromatherapy	Fragrance, pleasure, hygiene	Non-reimbursable.
	Therapeutic	Non-reimbursable. See alternative medicine.
Arthritis treatment		Reimbursable, subject to the limitations and exclusions of the Plan.
Artificial	Arms	Reimbursable, subject to the limitations and exclusions of the Plan. See prosthetic appliances.
	Ears	
	External breast prostheses	
	Hands	
	Hip joints	
	Larynx	
	Legs	
	Nose	
Artificial insemination		Non-reimbursable. See also infertility treatment.
Assisted hatching (AHA)		Non-reimbursable. See infertility treatment.
Assisted microfertilization		Non-reimbursable. See infertility treatment and intracytoplasmic sperm injection (ICSM).
Auriculotherapy (ear acupuncture)		Reimbursable for chronic pain treatment only, subject to the limitation and exclusions of the Plan. See acupuncture.
Ayurvedic medicine		Non-reimbursable. See alternative medicine.
Bionergetic therapy		Non-reimbursable. See alternative medicine.
Biofeedback therapy		Non-reimbursable. See alternative medicine.
Blastocyst embryo transfer (BET)		Non-reimbursable. See infertility treatment.
Blepharoplasty		Non-reimbursable. See plastic surgery.

Expense type		Is it reimbursable?
Blood, blood products, blood derivatives		Reimbursable if prescribed by the attending physician at the rate of: (a) 80 per cent if outpatient; (b) 100 per cent if inpatient.
Blood glucose monitors		Reimbursable at the rate of 80 per cent if prescribed by the attending physician for the management of diabetes. Includes monitors for the legally blind. Testing strips for the glucose monitors are also covered by the Plan.
Blood pressure measurement devices		Reimbursable at the rate of 80 per cent if prescribed by the attending physician to monitor a chronic medical condition. The prescription must indicate the medical condition requiring the device.
Bone marrow transplant		Reimbursable, subject to the limitations and exclusions of the Plan. See hospital services and supplies.
Braces		See orthodontics.
Breast plastic surgery		See plastic surgery. Surgery following mastectomy of a diseased breast is reimbursable.
Breast enlargement or reduction	To improve, alter or enhance appearance	Non-reimbursable, whether or not for psychological or emotional reasons.
	To improve the function of a part of the body	Normally reimbursable, subject to the limitations and exclusions of the Plan. Case should be referred to Cigna for review and approval.
Breast reconstruction		See plastic surgery. Surgery following mastectomy of a diseased breast is reimbursable.
Bridges		Reimbursable, subject to the limitations and exclusions of the Plan. See dental prosthetic services.
Bunion surgery		Reimbursable, subject to the limitations and exclusions of the Plan. See podiatry.
Calcium		Normally non-reimbursable. Only reimbursable if prescribed by the attending physician to treat a medical condition (for example, osteoporosis) at the rate of: (a) 80 per cent if outpatient; (b) 100 per cent if inpatient. Attending physician must indicate condition to be treated and length of treatment. If the duration of the treatment exceeds three months, the attending physician must reassess the treatment and issue a new prescription. Tests must be attached.

Expense type	Is it reimbursable?
Carbon dioxide therapy	Non-reimbursable.
Cardiac electrophysiology	Reimbursable, subject to the limitations and exclusions of the Plan.
Cardiology	Reimbursable, subject to the limitations and exclusions of the Plan.
Cardiovascular surgery	Reimbursable, subject to the limitations and exclusions of the Plan.
Cardiovascular treatment	Reimbursable, subject to the limitations and exclusions of the Plan.
Carpal Tunnel Syndrome surgery	Reimbursable, subject to the limitations and exclusions of the Plan. See hospital services and supplies.
Chemical dependency	Reimbursable, subject to the limitations and exclusions of the Plan. See substance abuse.
Chemotherapy	Reimbursable, subject to the limitations and exclusions of the Plan.
Chinese clinics	Non-reimbursable. See alternative medicine.
Chinese taoism	Non-reimbursable. See alternative medicine.
Chiropractic care	Reimbursable at the rate of 80 per cent provided: (a) There is a medical condition that requires treatment; (b) The treatment is conducted by a qualified medical doctor or a licensed chiropractor; (c) Treatment is recognized as a valid treatment modality by the competent health authorities of the country. Attending physician's prescription must specify: (a) Type of treatment to be rendered; (b) Number of sessions; (c) Actual length of treatment. If the duration of the treatment exceeds three months, the attending physician must reassess the medical condition and issue a new prescription. See alternative medicine.
Chiropody	Reimbursable, subject to the limitations and exclusions of the Plan. See podiatry.
Circumcision (male)	Reimbursable.

Expense type	Is it reimbursable?
Collagen therapy	Non-reimbursable.
Colonic irrigation	Reimbursable at the rate of 80 per cent if prescribed by the attending physician to treat a medical condition. The attending physician's prescription must indicate the medical condition requiring colonic irrigation.
Colon cancer screening, including methods such as sigmoidoscopy, barium enema X-ray and colonoscopy	Reimbursable, subject to the limitations and exclusions of the Plan. See hospital services and supplies.
Colostomy surgery	Reimbursable, subject to the limitations and exclusions of the Plan. See hospital services and supplies.
Colostomy bags	Reimbursable at the rate of 80 per cent if prescribed by the attending physician to treat a medical condition. The attending physician's prescription must indicate the medical condition requiring colostomy bags.
Computerized tomographic (CT)	Reimbursable, subject to the limitations and exclusions of the Plan. See scanning.
Contact lenses solutions	Non-reimbursable.
Contraceptive devices and medication	Reimbursable at the rate of 80 per cent with the exception of condoms.
Coronary artery bypass surgery	Reimbursable, subject to the limitations and exclusions of the Plan. See hospital services and supplies.
Correction of eye refractive errors	See laser optical treatment of myopia and astigmatism
Corrective heels	See orthopaedic heels.
Corrective lenses (including contact lenses, disposable lenses, bifocal or trifocal lenses or lenses of progressive focal length or any other corrective lens)	Reimbursable at the rate of 80 per cent, subject to a waiting period of one year from date of purchase with a maximum of $75 per lens and a maximum of two lenses annually (per eligible patient) provided there is a change in the lens prescription. Periodicity is not reduced for the replacement of lenses that are lost, stolen or broken.
Corrective shoes	See orthopaedic shoes.
Cosmetic surgery	Non-reimbursable, including breast enlargement or reduction. See plastic surgery.

Expense type		Is it reimbursable?
Counselling	Bereavement	Non-reimbursable.
	Career	
	Child	
	Family	
	Financial	
	Legal	
	Pastoral	Non-reimbursable.
	Social adjustment	
Craniosacral therapy		Non-reimbursable. See alternative medicine.
Critical care medicine		Reimbursable, subject to the limitations and exclusions of the Plan.
Crohn's disease treatment		Reimbursable at the rate of 80 per cent.
Crowns		See dental prosthetic services.
Crutches		Reimbursable at the rate of 80 per cent if prescribed by the attending physician as medically necessary. See durable medical equipment.
Custodial care		Non-reimbursable.
Dandruff lotions and shampoos		Non-reimbursable. See parapharmaceutical products and hair lotions and shampoos.
Dehumidifiers		Non-reimbursable.
Dental prosthetic services		Reimbursable at the rate of 80 per cent, subject to the maximum benefit under dental care per calendar year; that is, one half the MIP reference salary for each eligible patient. The Plan also covers: (a) Replacement when ordered in cases of wear, damage or change in the patient's condition or body structure; (b) Reasonable costs for repairing, fitting, maintaining and adjusting appliances/devices.
Dental restorations (fillings)		Reimbursable at the rate of 80 per cent, subject to the maximum benefit under dental care per calendar year; that is, one half the MIP reference salary for each eligible patient.
Dental floss		Non-reimbursable.

Expense type		Is it reimbursable?
Dento-facial orthodontics		Reimbursable at 80 per cent if treatment is started before patient is 15 years of age; treatment period up to four years. Exception to age: in case of an accident and treatment is undertaken within 12 months of the accident. See orthodontics.
Dentures		Reimbursable, subject to the limitations and exclusions of the Plan. See dental prosthetic services.
Dermatology		Reimbursable at the rate of 80 per cent, provided it is to treat disorders of the skin. Treatment must be conducted by a qualified medical doctor.
Developmental delays		Charges for or related to education testing, services training or treatment are non-reimbursable.
Diabetes treatment		Reimbursable, subject to the limitations and exclusions of the Plan.
Diagnostic laboratory		Reimbursable, subject to the limitations and exclusions of the Plan. See laboratory tests.
Dialysis		See kidney hemodialysis and peritoneal dialysis.
Dietary food products		Non-reimbursable. See parapharmaceutical products.
Dietician		Only reimbursable if prescribed by the attending physician to treat a medical condition, for example, diabetes, at the rate of: (a) 80 per cent if outpatient; (b) 100 per cent if inpatient. Attending physician must indicate condition to be treated and length of treatment.
Drug abuse		Reimbursable, subject to the limitations and exclusions of the Plan. See substance abuse.
Drugs (over-the-counter)		Reimbursable at 80 per cent if prescribed by a physician for a specific diagnosed disease. Otherwise, non-reimbursable.
Drugs (prescription)	Emergency	Reimbursable at the rate of: (a) 100 per cent if for emergency care and/or use in the hospital; (b) 80 per cent if for non-emergency care or for use outside the hospital. See hospital emergency room supplies and services.

Expense type		Is it reimbursable?
	Inpatient	Reimbursable at the rate of 100 per cent if prescribed by the attending physician and for use in the hospital.
	Outpatient	Reimbursable at the rate of 80 per cent if prescribed by the attending physician. Attending physician's prescription must specify the length of treatment. A prescription may cover for treatment or use up to one year, provided the attending physician clearly and specifically indicates that drug treatment is required for the whole year. Reimbursement is limited to up to a three-month supply at a time. If the duration of the treatment exceeds one year, the attending physician must reassess the treatment and issue a new prescription.
	Replacement of drugs resulting from loss, theft or breakage	Non-reimbursable.
Durable medical equipment		The Plan reimburses rental (or purchase when more economical or if equipment cannot be rented) at the rate of 80 per cent if prescribed by the attending physician as medically necessary. The prescription must indicate the medical condition requiring the equipment. If the equipment is not included in this list and there are doubts as to whether it is reimbursable, please check with Cigna.
Eczema treatment		Reimbursable, subject to the limitations and exclusions of the Plan. See skin diseases.
Electric toothbrush		Non-reimbursable.
Embryo co-culture		Non-reimbursable. See infertility treatment.
Embryo cryopreservation (freezing)		Non-reimbursable. See infertility treatment.
Employment examinations		Non-reimbursable.
Endocrinology		Reimbursable, subject to the limitations and exclusions of the Plan.
Endodontics		Reimbursable at the rate of 80 per cent, subject to the maximum benefit under dental care per calendar year, that is, one-half the MIP reference salary for each eligible patient.
Enzyme therapy		Non-reimbursable. See alternative medicine.
Epididymal aspiration		Non-reimbursable. See infertility treatment.

Expense type		Is it reimbursable?
Evacuation		Non-reimbursable under MIP. See provisions for medical evacuation in administrative instruction ST/AI/2000/10 and information circular ST/IC/2000/70 on medical evacuation. Only medical expenses related to the evacuation may be covered under the Plan.
Exercise equipment		Non-reimbursable.
Experimental	Biologicals	Non-reimbursable.
	Devices	
	Drugs	
	Procedures	
	Technology	
	Treatment	
Eye examinations	Mandatory periodic for drivers	Non-reimbursable under MIP. Please check with your local human resources office.
	Routine	Reimbursable at the rate of 80 per cent, subject to one exam every 12 months (per eligible patient), up to a maximum of $100. The examination must be carried out by an ophthalmologist.
	To treat an injury	Reimbursable at the rate of 80 per cent. The examination must be carried out by an ophthalmologist.
	To treat a medical condition	
Eyeglass frames		Reimbursable at the rate of 80 per cent, subject to a waiting period of one year from date of purchase, with a maximum of $50 per frame and a maximum of one frame every 24 months (per eligible patient).
Facelift		Non-reimbursable. See plastic surgery and rhytidectomy.
Facial chemical peels		Non-reimbursable.
Facial collagen therapy		Non-reimbursable.
False teeth		Reimbursable, subject to the limitations and exclusions of the Plan. See dental prosthetic services.
Family planning — office visits, including tests and counselling		Reimbursable at the rate of 80 per cent.
Fitness programmes		Non-reimbursable.

Expense type		Is it reimbursable?
Foot care	Corns	Non-reimbursable.
	Calluses	
	Toe nails	
Food supplements		Normally non-reimbursable. Only reimbursable if prescribed by the attending physician to treat a medical condition (for example, anaemia) at the rate of: (a) 80 per cent if outpatient; (b) 100 per cent if inpatient. Attending physician must indicate condition to be treated and length of treatment. If the duration of the treatment exceeds three months, the attending physician must reassess the treatment and issue a new prescription. Laboratory tests must be attached.
Foot orthotics		Normally reimbursable, subject to the limitations and exclusions of the Plan. See orthotic appliances/devices.
Foot plastic surgery		See plastic surgery and hospital services/supplies.
Functional rehabilitation		Reimbursable, subject to the limitations and exclusions of the Plan. See physical therapy.
Gastroenterology		Reimbursable, subject to the limitations and exclusions of the Plan.
Gemstone/crystal/chakra therapy		Non-reimbursable. See alternative medicine.
Geriatric medicine		Reimbursable, subject to the limitations and exclusions of the Plan.
Gamete intrafallopian transfer (GIFT)		Non-reimbursable. See infertility treatment.
Gynaecology		Reimbursable, subject to the limitations and exclusions of the Plan.
Gynecological examination		Reimbursable at the rate of 80 per cent. See routine examinations.
Haematology		Reimbursable, subject to the limitations and exclusions of the Plan.
Hair	Implants	Non-reimbursable.
	Transplants	

Expense type		Is it reimbursable?
Hair lotions and shampoos	Regular	Non-reimbursable. See parapharmaceutical products.
	Medicated/prescription	Only reimbursable at the rate of 80 per cent if prescribed by the attending physician to treat a medical condition (for example, seborrheic dermatitis) and provided the hair lotion/shampoo is not an over-the-counter product. Attending physician must indicate condition to be treated and length of treatment. If the duration of the treatment exceeds three months, the attending physician must reassess the treatment and issue a new prescription.
Hand plastic surgery		See plastic surgery and hospital services/supplies.
Hearing aids/devices		Reimbursable at the rate of 80 per cent, subject to a waiting period of one year, with a maximum of $300 per apparatus, every three calendar years (one for each ear, if appropriate) per eligible patient. Prescriptions must be accompanied by an audiogram. The periodicity is not reduced for the replacement of aids that are lost, stolen or broken.
Hearing evaluation and audiometric exam		Reimbursable at the rate of 80 per cent, subject to one exam every three years. An otolaryngologist or a certified audiologist must carry out the examination.
Hearing therapy		Reimbursable at the rate of 80 per cent if to improve or restore hearing function that has been lost or impaired as a result of a disease, injury or congenital defect. Benefits are not provided for maintenance therapy designed to prevent deterioration of the hearing function. Attending physician's prescription must specify: (a) Type of treatment to be rendered; (b) Number of sessions; (c) Actual length of treatment. If the duration of the treatment exceeds three months, the treating physician must reassess the treatment and issue a new prescription.
Heart valve replacement surgery		Reimbursable, subject to the limitations and exclusions of the Plan. See hospital services and supplies.
Heating pads		Non-reimbursable. See alternative medicine.
Hepatitis		Reimbursable, subject to the limitations and exclusions of the Plan. See drugs.

Expense type	Is it reimbursable?
Herbal medicine	Reimbursable at the rate of 80 per cent provided: (a) There is a medical condition that requires treatment; (b) Treatment is recognized as a valid treatment by the competent health authorities of the country; (c) Treatment is rendered by a qualified medical doctor. See alternative medicine.
Herpes treatment	Reimbursable, subject to the limitations and exclusions of the Plan. See skin diseases.
Hip surgery	Reimbursable, subject to the limitations and exclusions of the Plan. See hospital services and supplies.
HIV tests	Reimbursable at the rate of 100 per cent. Two voluntary blood tests and related counselling per year per eligible family member; that is, no prescription required. Additional tests during the same year require a prescription from a medical doctor.
HIV/AIDS test counselling	See HIV tests.
Home health care	Reimbursable at the rate of 80 per cent if prescribed by the attending physician as medically necessary and as an alternative to either hospitalization, or a stay in a skilled nursing facility. Attending physician's prescription must indicate: (a) Medical condition requiring home health care; (b) Treatment plan, including type and length. If the duration of the treatment exceeds three months, the attending physician must reassess treatment and issue a new prescription. Services must be rendered by a qualified nurse or a certified home health-care agency duly licensed to operate as such. The benefit does not cover charges made for a person who usually lives with the patient, who is a member of his/her family or who is a member of his/her spouse's family.
Homeopathy	Reimbursable at the rate of 80 per cent provided: (a) There is a medical condition that requires treatment; (b) Treatment is recognized as a valid treatment by the competent health authorities of the country; (c) Treatment is rendered by a qualified medical doctor. See alternative medicine.

Expense type		Is it reimbursable?
Homeopathic products		Reimbursable at the rate of 80 per cent provided: (a) Products are prescribed to treat a medical condition; (b) Products are prescribed by a qualified medical doctor; (c) Products are recognized as a valid treatment modality by the competent health authorities of the country. See alternative medicine.
Hospital emergency room services and supplies	For emergency care	Reimbursable at the rate of 100 per cent if the medical condition, the onset of which is sudden, manifests itself by symptoms of such severity, including severe pain, that a prudent lay person with an average knowledge of medicine and health could reasonably expect that the absence of immediate medical attention would result in: (a) Placing the health of the afflicted person in serious jeopardy; (b) Placing the health of an individual with a behavioural health condition or others in serious jeopardy; (c) Causing serious impairment to the individual's bodily functions; (d) Causing serious dysfunction of any bodily organ or part; (e) Causing serious disfigurement of the afflicted individual.
	For non-emergency care	Reimbursable at the rate of 80 per cent, when used for example: (a) Because it is late at night and the need for treatment is not sudden and serious; (b) Because the patient has no regular physician.

Expense type		Is it reimbursable?
Hospital services and supplies for inpatients and ambulatory or one-day surgeries	Accommodation	Reimbursable at the rate of: (a) If semi-private accommodation (two or more patients in the same room): 100 per cent; (b) If private accommodation: 70 per cent of the rate of private accommodation or 100 per cent of semi-private accommodation, whichever is greater. Only under the following circumstances, subject to provision of documentation satisfactory to Cigna, private accommodation will be reimbursable in full: (i) When the nature and gravity of the illness requires private-room care and the need for such care is duly substantiated by the attending physician; (ii) When the patient is admitted on an emergency basis to a hospital that has semi-private accommodation but none is available at the time of admission. This will be considered only until semi-private accommodation becomes available; (iii) When the patient is admitted to a hospital that does not have any semi-private accommodation, that is, it has no standard of accommodation other than general wards.
	Drugs and medicines	Reimbursable at the rate of 100 per cent as long as they are for use in hospital.
	General hospital nursing	Reimbursable at the rate of 100 per cent.
	Intensive care room	
	Laboratory examinations	
	Medical equipment	
	Operating room/theatre	
	Recovery room	
	X-ray examinations	
	Anaesthesiologist's fees	Reimbursable at the rate of 100 per cent.
	Physician's fees (specialists and non-specialists)	
	Surgeon's fees	

Expense type		Is it reimbursable?
	Extra bed	Reimbursable at 80 per cent for one accompanying adult during a hospitalization of a Plan member under the age of 13 or if required by local legislation. Otherwise, non-reimbursable.
	Food for persons other than the patient	Non-reimbursable.
	Telephone/fax	
	Television	
Hospital-type beds		The Plan reimburses rental (or purchase when more economical) at the rate of 80 per cent, if prescribed as medically necessary. Prescription must indicate the medical condition requiring the hospital-type bed. See durable medical equipment.
Hot water bottle		Non-reimbursable.
Hypnosis		Non-reimbursable.
Immunizations	Adults and children	Reimbursable at the rate of 100 per cent if recommended by the local health authorities and/or the World Health Organization.
	Personal travel	Non-reimbursable.
	Official travel	Non-reimbursable. Immunizations required for official travel are considered travel expenses and, therefore, non-reimbursable under MIP. Staff member should include expenses as part of his/her travel claim if not provided at no cost by the medical unit at the duty station.
Immunology		Reimbursable, subject to the limitations and exclusions of the Plan.
Impotence/erectile dysfunction		Medication to temporarily treat condition (for example, Viagra, Levitra, etc.) is reimbursable only if prescribed by a doctor for the following conditions: (a) Prostatectomy (surgical removal of all or part of the prostate gland); (b) In case of diabetic neuropathy (nerve damage as a result of high blood sugar levels). The prescription must include the patient's diagnosis. Maximum reimbursement is 6 tablets per month. Medication due to impotence/erectile dysfunction as a result of ageing or psychogenic impotence is not reimbursable.

Expense type		Is it reimbursable?
Infertility treatment		Assisted reproductive treatments are non-reimbursable, for example, blastocyst embryo transfer (BET); gamete intrafallopian transfer (GIFT); in vitro fertilization (IVF); intracytoplasmic sperm injection (ICSI); intrauterine insemination (IUI); percutaneous epididymal sperm aspiration (PESA); testicular sperm extraction (TESE); testicular sperm aspiration (TESA); tubal embryo transfer (TET); and zygote intrafallopian transfer (ZIFT).
Infrared lamp		Reimbursable at the rate of 80 per cent if prescribed by the attending physician to treat a medical condition. The attending physician's prescription must indicate the medical condition requiring the infrared lamp.
Insulin		Reimbursable if prescribed by the attending physician, at the rate of: (a) 80 per cent if outpatient; (b) 100 per cent if inpatient.
Insulin	Cartridges for the legally blind	Reimbursable at the rate of 80 per cent if prescribed by the attending physician for the management of diabetes.
	Infusion devices	
	Injection aids	
	Pumps and appurtenances	
	Syringes	
Intentional accidents/injuries		Non-reimbursable. See self-inflected accidents/injuries.
Internal medicine		Reimbursable, subject to the limitations and exclusions of the Plan.
Intracytoplasmic sperm injection (ICSI), assisted microfertilization		Non-reimbursable. See infertility treatment.
Intrauterine insemination (IUI)		Non-reimbursable. See infertility treatment.
Intravenous oxidative therapy		Non-reimbursable.
Investigational	Biologicals	Non-reimbursable.
	Devices	
	Drugs	
	Procedures	
	Technology	
	Treatments	

Expense type		Is it reimbursable?
In vitro fertilization (IVF)		Non-reimbursable. See infertility treatment.
Iridology		Non-reimbursable. See alternative medicine.
Karate		Non-reimbursable. See alternative medicine.
Kidney	Hemodialysis	Plan covers treatment at home, or in a hospital-based or free-standing facility. For home treatment, the Plan reimburses rental (or purchase when more economical or equipment cannot be rented) at the rate of 80 per cent of equipment and all necessary supplies required for physician-ordered home dialysis treatment. Coverage, however, does not include any of the following: (a) Furniture; (b) Electrical, plumbing or other fixtures; (c) Professional assistance needed to perform home dialysis treatment.
	Peritoneal dialysis	
Knee brace contour		Reimbursable, subject to the limitations and exclusions of the Plan. See orthotic appliances/devices.
Labial frenum removal		Reimbursable, subject to the limitations and exclusions of the Plan. See oral surgery.
Laboratory tests	Emergency room	Reimbursable at the rate of: (a) 100 per cent if for emergency care; (b) 80 per cent if for non-emergency care. See hospital emergency room services and supplies.
	Inpatient	Reimbursable at the rate of 100 per cent.
	Outpatient	Reimbursable at the rate of 80 per cent if prescribed by the attending physician.
Laser optical treatment of myopia and astigmatism		Reimbursable, subject to a one-year waiting period, at the rate of 80 per cent, subject to a maximum of $150 per eye per eligible patient and to prior authorization.
Laser removal of hair		Non-reimbursable.
Laser removal of tattoos		Non-reimbursable.
Learning disabilities		Charges for or related to education testing, services, training or treatment are non-reimbursable.
Lenses		See corrective lenses.

Expense type		Is it reimbursable?
Lingual frenum removal		Reimbursable, subject to the limitations and exclusions of the Plan. See oral surgery.
Liposuction		Non-reimbursable. See cosmetic surgery and removal of excess fat.
Magnetic-field therapy		Non-reimbursable. See alternative medicine.
Magnetic resonance imaging (MRI)		Reimbursable, subject to the limitations and exclusions of the Plan. See scanning.
Mammography		Reimbursable at the rate of 80 per cent. See routine examinations.
Mandible surgery		Reimbursable, subject to the limitations and exclusions of the Plan. See oral surgery.
Massage devices		Non-reimbursable.
Massage therapy		Non-reimbursable. See alternative medicine.
Maternity		Reimbursable, subject to the limitations and exclusions of the Plan. See hospital services.
Maxilar surgery		Reimbursable, subject to the limitations and exclusions of the Plan. See oral surgery.
Maxillofacial surgery		Reimbursable, subject to the limitations and exclusions of the Plan. See oral surgery.
Medications (over-the-counter)		Non-reimbursable.
Medicinal wines		Non-reimbursable. See parapharmaceutical products.
Meditation therapy		Non-reimbursable. See alternative medicine.
Megavitamin therapy		Non-reimbursable.
Mental health and nervous care	Inpatient	Reimbursable, subject to the limitations and exclusions of the Plan. See hospital services and supplies. The outpatient reimbursable rate of 80 per cent up to a maximum of one MIP reference salary in each calendar year (per eligible patient) does not apply.
	Outpatient	Reimbursable at the rate of 80 per cent up to a maximum of one MIP reference salary in each calendar year (per eligible patient). Services must be provided by a licensed psychiatrist, licensed psychoanalyst, licensed psychologist or a licensed psychiatric social worker. See psychiatry, psychology and psychotherapy.

Expense type		Is it reimbursable?
Midwifery services		Reimbursable at the rate of 80 per cent.
Military service accidents/injuries in time of war		Non-reimbursable.
Mind/body therapy		Non-reimbursable. See alternative medicine.
Mineral waters		Non-reimbursable. See parapharmaceutical products.
Mouthwash		Non-reimbursable.
Multiple Sclerosis treatment		Reimbursable, subject to the limitations and exclusions of the Plan.
Music therapy		Non-reimbursable. See alternative medicine.
Naturophatic therapy		Non-reimbursable. See alternative medicine.
Nebulizer		Reimbursable at the rate of 80 per cent if prescribed by the attending physician to treat a medical condition. The attending physician's prescription must indicate the medical condition requiring the nebulizer.
Neonatology		Reimbursable, subject to the limitations and exclusions of the Plan.
Nephrology		Reimbursable, subject to the limitations and exclusions of the Plan.
Neurology		Reimbursable, subject to the limitations and exclusions of the Plan.
Neurosurgery		Reimbursable, subject to the limitations and exclusions of the Plan. See hospital services and supplies.
Non-smoking cures		Non-reimbursable.
Non-surgical facelift		Non-reimbursable.
Nuclear medicine		Reimbursable, subject to the limitations and exclusions of the Plan.
Nuclear radiology		Reimbursable, subject to the limitations and exclusions of the Plan. See radiology.
Nursing services	General hospital nursing	Reimbursable at the rate of 100 per cent.
	Private hospital duty nursing	Non-reimbursable.

Expense type		Is it reimbursable?
	Private home duty nursing	Reimbursable at the rate of 80 per cent if prescribed by attending physician as medically necessary. Attending physician's prescription must indicate: (a) Medical condition requiring home health care; (b) Treatment plan, including type and length. If the duration of the treatment exceeds three months, the attending physician must reassess the treatment and issue a new prescription. Services must be rendered by a qualified nurse. This benefit does not cover charges made for a person who usually lives with the patient, who is a member of his/her family or who is a member of his/her spouse's family.
Nutritional supplements		Normally non-reimbursable. Only reimbursable if prescribed by the attending physician to treat a medical condition (for example, anaemia) at the rate of: (a) 80 per cent if outpatient; (b) 100 per cent if inpatient. Attending physician must indicate condition to be treated and length of treatment. If the duration of the treatment exceeds three months, the attending physician must reassess the treatment and issue a new prescription. Laboratory tests must be attached.
Obesity treatment		Reimbursable at a rate of 80 per cent if prescribed by attending physician as medically necessary.
Obstetrics	Staff member or spouse	Reimbursable, subject to the limitations and exclusions of the Plan.
Obstetrics	Child under 25 years old	Only reimbursable, subject to the limitations and exclusions of the Plan, if the child under age 25[b] lives with the staff member. The newborn child is NOT covered under the Plan.
Occupational therapy		Reimbursable, subject to the limitations and exclusions of the Plan. See physical therapy.
Oncology		Reimbursable, subject to the limitations and exclusions of the Plan.
Ophthalmology		Reimbursable, subject to the limitations and exclusions of the Plan.

[b] An eligible child is covered under MIP until the last day of the year that the child turns age 25.

Expense type	Is it reimbursable?
Orthomolecular therapy	Non-reimbursable. See alternative medicine.
Osteoporosis treatment	Reimbursable, subject to the limitations and exclusions of the Plan.
Otolaryngology	Reimbursable, subject to the limitations and exclusions of the Plan.
Otology	Reimbursable, subject to the limitations and exclusions of the Plan.
Otorhinolaryngology	Reimbursable, subject to the limitations and exclusions of the Plan.
Oral biopsy and examination of oral tissue	See oral surgery.
Oral cyst removal	See oral surgery.
Oral extractions	See oral surgery.
Oral incision and drainage of abscess	See oral surgery.
Oral irrigator	Non-reimbursable.
Oral surgery	Reimbursable at the rate of 80 per cent and normally, subject to the maximum benefit under dental care per calendar year; that is, one half the MIP reference salary for each eligible patient. Only the following surgeries are not subject to the maximum dental care benefit: (a) To treat a fracture, dislocation or wound; (b) To cut out: (i) Teeth partly or completely impacted in the bone of the jaw; (ii) Teeth that will not erupt through the gum; (iii) Other teeth that cannot be removed without cutting into bone; (iv) Roots of a tooth without removing the entire tooth; (v) Cysts, tumors or other diseased tissues; (c) To cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement or repair of teeth; (d) To alter the jaw, jaw joints or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement;

Expense type	Is it reimbursable?
	(e) To remove impacted damaged teeth injured in an accident, the treatment must be done within 12 months of the accident. Any such teeth must have been: free from decay; or in good repair; and firmly attached to the jaw bone at the time of the injury. If there are doubts whether an oral surgery is not subject to the maximum dental care benefit, please contact Cigna.
Oral water pik	Non-reimbursable.
Orthodontics	Reimbursable at the rate of 80 per cent if treatment started before 15 years old, except serious accident cases, subject to the maximum benefit under dental care per calendar year; that is, one half the MIP reference salary for each eligible patient. Maximum treatment period is four years.
Orthopaedics	Reimbursable, subject to the limitations and exclusions of the Plan.
Orthopaedic appliances/devices	Normally reimbursable at the rate of 80 per cent if prescribed by the attending physician as medically necessary to treat a medical condition. The prescription must indicate the medical condition requiring the appliance/device. If the appliance/device is not included in this list and there are doubts as to whether it is reimbursable, please check with Cigna. The Plan covers: (a) Replacement of purchased appliances/devices when ordered by the attending physician in cases of wear, damage or change in the patient's condition or body structure, and it costs less to replace than repair; (b) Reasonable costs for repairing, fitting, maintaining and adjusting appliances/devices.
Orthopaedic heels or shoes	Reimbursable, subject to the limitations and exclusions of the Plan. See orthopaedic appliances/devices.
Orthotic appliances/devices	Normally reimbursable at the rate of 80 per cent if prescribed by attending physician as medically necessary to support part or all of a body function or organ. The prescription must indicate the medical condition requiring the appliance/device. If the appliance/device is not included in this list and there are doubts as to whether it is reimbursable, please check with Cigna. The Plan covers: (a) Replacement of purchased appliances/devices when ordered by the attending physician in cases of wear, damage or change in the patient's condition or body structure, and it costs less to replace than to repair;

Expense type	Is it reimbursable?
	(b) Reasonable costs for repairing, fitting, maintaining and adjusting appliances/devices.
Over-the-counter medication coverage	See drugs (over-the-counter).
Oxidative therapy	See intravenous oxidative therapy.
Oxygen equipment	The Plan reimburses rental (or purchase when more economical or equipment cannot be rented) at the rate of 80 per cent, if prescribed by the attending physician, as medically necessary. The prescription must indicate the medical condition requiring the oxygen equipment. See durable medical equipment.
Pacemaker	Reimbursable, subject to the limitations and exclusions of the Plan.
Pacemaker implantation surgery	Reimbursable, subject to the limitations and exclusions of the Plan. See hospital services and supplies.
Painless delivery preparation	Reimbursable at the rate of 80 per cent.
Pap smear	Reimbursable at the rate of 80 per cent. See routine examinations.
Parapharmaceutical products	Non-reimbursable.
Pathology	Reimbursable, subject to the limitations and exclusions of the Plan.
Paediatric orthotic appliances/devices	Reimbursable, subject to the limitations and exclusions of the Plan. See orthotic appliances/devices.
Paediatrics	Reimbursable, subject to the limitations and exclusions of the Plan.
Percutaneous epididymal sperm aspiration (PESA)	Non-reimbursable. See infertility treatment.
Perinatology	Reimbursable, subject to the limitations and exclusions of the Plan.
Periodontics	Reimbursable at the rate of 80 per cent, subject to the maximum benefit under dental care per calendar year; that is, one half the MIP reference salary for each eligible patient.
Permanent cosmetic make-up (for example, eyeliners, eyebrows, lipliners)	Non-reimbursable.
Physical medicine and rehabilitation	Reimbursable, subject to the limitations and exclusions of the Plan. See physical therapy.

Expense type		Is it reimbursable?
Physical therapy		Reimbursable at the rate of 80 per cent if to improve or restore bodily functions that have been lost or impaired as a result of a disease, injury or congenital defect. Benefits are not provided for maintenance therapy designed to prevent deterioration of bodily functions. The attending physician's prescription must indicate: (a) Bodily function to be improved or restored; (b) Type of treatment; (c) Number of sessions; (d) Actual length of treatment. If the duration of the treatment exceeds six months, the attending physician must reassess the treatment and issue a new prescription. Therapy must be rendered by a qualified medical doctor or licensed physiotherapist.
Physicians' services — both specialists and non-specialists (except for mental health and substance abuse)	Home visits	Reimbursable at the rate of 80 per cent.
	In-hospital visits	Reimbursable at the rate of 100 per cent in connection with inpatient hospitalization. Otherwise, see office visits.
	Office visits	Reimbursable at the rate of 80 per cent.
	Surgery	Reimbursable at the rate of 100 per cent in connection with inpatient hospitalization.
Plastic facial surgery		See plastic surgery.
Plastic surgery	To improve, alter or enhance appearance	Non-reimbursable whether or not for psychological or emotional reasons.
	To improve the function of a part of the body	Reimbursable subject to the limitations and exclusions of the Plan when the part of the body is malformed: (a) As a result of a severe birth defect; this includes harelip or webbed fingers or toes; (b) As a direct result of disease or surgery performed to treat a disease or injury.
	To repair an injury	Reimbursable, subject to the limitations and exclusions of the Plan. See hospital services and supplies.
Podiatry		Reimbursable at the rate of 80 per cent provided it is to treat disorders of the foot. Treatment must be conducted by a qualified medical doctor.

Expense type	Is it reimbursable?
Positron emission tonographic (PET)	Reimbursable, subject to the limitations and exclusions of the Plan. See scanning.
Pregnancy tests	Non-reimbursable.
Premarital examinations	Non-reimbursable.
Primal therapy	Non-reimbursable.
Proctology	Reimbursable, subject to the limitations and exclusions of the Plan.
Prophylaxes (tooth cleaning)	Reimbursable at the rate of 80 per cent, subject to two per calendar year (per eligible patient) and the maximum benefit under dental care per calendar year; that is, one half the MIP reference salary for each eligible patient.
Prostate specific antigen (PSA)	Reimbursable at the rate of 80 per cent. See routine examinations.
Prosthetic appliances/devices	Normally reimbursable at the rate of 80 per cent if prescribed by attending physician as medically necessary to support part or all of a body function or organ. The prescription must indicate the medical condition requiring the appliance/device. If the appliance/device is not included in this list and there are doubts as to whether it is reimbursable, please check with Cigna. The Plan covers: (a) Replacement of purchased appliances/devices when ordered by the attending physician in cases of wear, damage or change in the patient's condition or body structure, and it costs less to replace than to repair; (b) Reasonable costs for repairing, fitting, maintaining and adjusting appliances/devices.
Prosthodontics	Reimbursable at the rate of 80 per cent, subject to the maximum benefit under dental care per calendar year; that is, one half the MIP reference salary for each eligible patient.
Proteins	Normally non-reimbursable. Only reimbursable if prescribed by the attending physician to treat a medical condition (for example, anaemia) at the rate of: (a) 80 per cent if outpatient; (b) 100 per cent if inpatient. Attending physician must indicate condition to be treated and length of treatment. If the duration of the treatment exceeds three months, the attending physician must reassess the treatment and issue a new prescription. Laboratory tests must be attached.

Expense type	Is it reimbursable?
Psychiatry/outpatient psychiatric care for mental and nervous disorders, including alcohol/substance abuse	Reimbursable at the rate of 80 per cent, subject to the maximum benefit under mental and nervous care of one month MIP reference salary in any calendar year (per eligible patient). There is a 90-day limitation on the length of stay in a treatment facility. This limit may be waived for active staff members and must be requested from the United Nations Medical Director or the Chief Medical Officer in the duty station.
Psychodrama treatment	Non-reimbursable.
Psychology	Reimbursable at the rate of 80 per cent, subject to the maximum benefit under mental and nervous care of one month MIP reference salary in any calendar year (per eligible patient). Attending physician must indicate medical condition to be treated and length of treatment. If the duration of the treatment exceeds three months, the attending physician must issue a new prescription.
Psychotherapy	Reimbursable at the rate of 80 per cent, subject to the maximum benefit under mental and nervous care of one month MIP reference salary in any calendar year (per eligible patient). Attending physician must indicate medical condition to be treated and length of treatment. There is a 90-day limitation on the length of stay in a treatment facility. This limit may be waived for active staff members and must be requested from the United Nations Medical Director or the Chief Medical Officer in the duty station.
Pulpotomy	See endodontics.
Pulmonary medicine	Reimbursable, subject to the limitations and exclusions of the Plan.
Radiation oncology	Reimbursable at 100 per cent for all Plan participants outside of the hospital.
Radiological treatment	Reimbursable at 100 per cent for all Plan participants outside of the hospital.
Radionuclide	Reimbursable, subject to the limitations and exclusions of the Plan. See scanning.
Reconstructive surgery	See plastic surgery and hospital services/supplies.
Reflexology	Non-reimbursable. See alternative medicine.
Reflexotherapy	Non-reimbursable.
Rejuvenation cure	Non-reimbursable.

Expense type		Is it reimbursable?
Removal of bags around the eyes		Non-reimbursable. See cosmetic surgery and blepharoplasty.
Removal of	Tattoos	Non-reimbursable. See cosmetic surgery.
	Excess tissue and fat from the abdomen	
	Bunions	Reimbursable at the rate of 80 per cent, subject to the limitations and exclusions of the Plan.
Rest cures		Non-reimbursable.
Reshaping the nose		See plastic surgery and rhinoplasty.
Reverse salpingectomy (surgical sterilization)		Non-reimbursable.
Reverse vasectomy		Non-reimbursable.
Rheumatology		Reimbursable, subject to the limitations and exclusions of the Plan.
Rhinoplasty		See plastic surgery.
Rhytidectomy		Non-reimbursable. See cosmetic surgery and facelift.
Rolfing treatment		Non-reimbursable.
Root canal therapy (RCT)		See endodontics.
Routine examinations[c]	Children (including immunizations)	Reimbursable at the rate of 100 per cent, subject to the following limits: Birth to age 1: every 2 months Age 2 to 3: every 6 months Age 4 to 19: every year
	Men	One routine urological examination per year, including one prostate specific antigen (PSA) screening, at the rate of 80 per cent.
	Women	One routine gynaecological examination per year, including one pap smear and one mammography, at the rate of 80 per cent.
Routine physical examination		Reimbursable at the rate of 80 per cent for one annual routine physical for adults age 20 and over
Salpingectomy (surgical sterilization)		Reimbursable, subject to the limitations and exclusions of the Plan (reverse salpingectomy non-reimbursable).

[c] A routine examination is an examination given by a physician for a reason other than to diagnose or treat a suspected or identified injury or disease.

Expense type		Is it reimbursable?
Scanning	Computerized tomographic (CT)	Reimbursable if prescribed by the attending physician at the rate of: (a) 80 per cent if outpatient; (b) 100 per cent if inpatient.
	Magnetic resonance imaging (MRI)	
	Positron emission tomographic (PET)	
	Radionuclide (also called radioisotope)	
	Ultrasonic imaging	
Second surgical opinion		Reimbursable at the rate of 80 per cent.
Self-inflicted accidents/injuries		Non-reimbursable.
Semen cryopreservation (freezing)		Non-reimbursable. See infertility treatment and embryo cryopreservation.
Sexually transmitted diseases (STDs) treatment		Reimbursable, subject to the limitations and exclusions of the Plan.
Shampoos and hair lotions	Regular	Non-reimbursable. See parapharmaceutical products.
	Medicated/prescription	Only reimbursable at the rate of 80 per cent if prescribed by the attending physician to treat a medical condition (for example, seborrheic dermatitis) and provided the hair lotion/shampoo is not an over-the-counter product. Attending physician must indicate condition to be treated and length of treatment. If the duration of the treatment exceeds three months, the attending physician must reassess the treatment and issue a new prescription.
Shiatsu		Non-reimbursable. See alternative medicine.
Sign language lessons		Non-reimbursable.
Skilled nursing		See nursing services.
Skin diseases		Reimbursable, subject to the limitations and exclusions of the Plan.
Skin food		Non-reimbursable. See parapharmaceutical products.
Sleeping cures		Non-reimbursable.
Smoking cessation aids or drugs		Non-reimbursable.
Spa cures		Non-reimbursable.

Expense type		Is it reimbursable?
Speech therapy		Reimbursable at the rate of 80 per cent if to improve or restore speech function (the ability to express thoughts, speak words and form sentences) that has been lost or impaired as a result of a disease, injury or congenital defect. Benefits are not provided for maintenance therapy designed to prevent deterioration of speech function. Attending physician's prescription must specify: (a) Type of treatment; (b) Number of sessions; (c) Actual length of treatment. If the duration of the treatment exceeds three months, the treating physician must reassess the treatment and issue a new prescription.
Spinal orthotic appliances/devices		Reimbursable, subject to the limitations and exclusions of the Plan. See orthotic appliances/devices.
Sport accidents/ injuries	Dangerous hazardous or violent sports, for example, motorized sports, parachuting, gliding, boxing and martial arts	Non-reimbursable.
	Normal sports, for example, skiing, swimming	Reimbursable, subject to the limitations and exclusions of the Plan.
Stomach ulcer treatment		Reimbursable, subject to the limitations and exclusions of the Plan.
Substance abuse	Inpatient treatment for detoxification and rehabilitation	Reimbursable at the rate of 80 per cent, subject to the maximum benefit under mental and nervous care of one month MIP reference salary in any calendar year (per eligible patient) and provided it is carried out at a facility certified for detoxification and rehabilitation.
	Outpatient counselling for the purpose of diagnosis and treatment	Reimbursable at the rate of 80 per cent, subject to the maximum benefit under mental and nervous care of one month MIP reference salary in any calendar year (per eligible patient). Services must be provided by a licensed psychiatrist, licensed psychoanalyst, licensed psychologist or licensed psychiatric social worker. See psychiatry, psychology and psychotherapy.
Suction lipectomy		Non-reimbursable. See cosmetic surgery, liposuction and removal of excess fat.
Sugar free tablets		Non-reimbursable.

Expense type		Is it reimbursable?
Sun blocks		Non-reimbursable.
Sunglasses	Prescription	Reimbursable, subject to the limitations and exclusions of the Plan. See corrective lenses.
	Non-prescription	Non-reimbursable.
Support stockings for varicose veins		Reimbursable, subject to the limitations and exclusions of the Plan.
Surgery		See hospital services.
T'ai Chi		Non-reimbursable. See alternative medicine.
Telephone alert systems		Non-reimbursable.
Temporo-mandibular joint (TMJ) surgery		Reimbursable, subject to the limitations and exclusions of the Plan. See oral surgery.
Testicular sperm aspiration (TESA)		Non-reimbursable. See infertility treatment.
Testicular sperm extraction (TESE)		Non-reimbursable. See infertility treatment.
Therapeutic touch		Non-reimbursable. See alternative medicine.
Thermometers		Non-reimbursable.
Toiletries		Non-reimbursable.
Tooth restorations		Reimbursable, subject to the limitations and exclusions of the Plan. See dental restorations.
Toothbrush		Non-reimbursable.
Toothpaste	Regular	Non-reimbursable.
	Medicated/prescription	Only reimbursable at the rate of 80 per cent if prescribed by the attending dentist to treat a medical condition and provided the toothpaste is not an over-the-counter product. Attending dentist must indicate condition to be treated and length of treatment. If the duration of the treatment exceeds three months, the attending dentist must reassess the treatment and issue a new prescription.
Traditional medicine		See alternative medicine.
Tubal ligation (surgical sterilization)		Reimbursable, subject to the limitations and exclusions of the Plan. See salpingectomy.
Ultrasonic imaging		Reimbursable, subject to the limitations and exclusions of the Plan. See scanning.

Expense type	Is it reimbursable?
Urology	Reimbursable, subject to the limitations and exclusions of the Plan.
Vaccinations	See immunizations.
Varicose vein surgery	Reimbursable at the rate of 80 per cent if prescribed by the attending physician as medically necessary.
Vasectomy (surgical sterilization)	Reimbursable (reverse vasectomy not reimbursable).
Viagra	See impotence/erectile dysfunction.
Vision perception training	Non-reimbursable.
Vision therapy	Reimbursable at the rate of 80 per cent if to improve or restore vision function that has been lost or impaired as a result of a disease, injury or congenital defect. Benefits are not provided for maintenance therapy designed to prevent deterioration of vision function. Attending physician's prescription must specify: (a) Type of treatment; (b) Number of sessions; (c) Actual length of treatment. If the duration of the treatment exceeds three months, the treating physician must reassess the treatment and issue a new prescription.
Vitamins and minerals	Only reimbursable if prescribed by the attending physician to treat a medical condition (for example, anaemia) at the rate of: (a) 80 per cent if outpatient; (b) 100 per cent if inpatient. Attending physician must indicate condition to be treated and length of treatment. If the duration of the treatment exceeds three months, the attending physician must reassess the treatment and issue a new prescription. Laboratory tests must be attached. Multivitamins are non-reimbursable under the Plan under any condition.
Voluntary accidents/injuries	Non-reimbursable. See self-inflicted accidents/injuries.
Walking cane	Reimbursed at the rate of 80 per cent, if prescribed by the attending physician as medically necessary. See durable medical equipment.

Expense type		Is it reimbursable?
Wheelchair		The Plan reimburses rental (or purchase when more economical or wheelchair cannot be rented) at the rate of 80 per cent if prescribed by the attending physician as medically necessary. The prescription must indicate the medical condition requiring the wheelchair. See durable medical equipment.
Yeast infection treatment		Reimbursable, subject to the limitations and exclusions of the Plan. See drugs.
Yoga		Non-reimbursable. See alternative medicine.
X-rays	Emergency room	Reimbursable at the rate of: (a) 100 per cent if used for emergency care; (b) 80 per cent if used for non-emergency care. See hospital emergency room services and supplies.
	Inpatient	Reimbursable at the rate of 100 per cent.
	Outpatient	Reimbursable at the rate of 80 per cent if prescribed by the attending physician.
Zygote intrafallopian transfer (ZIFT)		Non-reimbursable. See infertility treatment.

United Nations ST/IC/2015/9

Secretariat

1 May 2015

Information circular*

To: Members of the staff

From: The Assistant Secretary-General for Human Resources Management

Subject: **Review of staff claims for dependency benefits for 2014**

1. The purpose of the present circular is to inform staff members of the manner in which the review of their entitlements to dependency benefits for 2014 will be conducted starting from 1 May 2015. See annex I for details on the types of dependency benefits, annex II for contact locations and annex III for information on the documentation required for the continuation of benefits. The entitlement to dependency allowance is established in staff rule 3.6 and implemented under administrative instruction ST/AI/2011/5, entitled "Dependency status and dependency benefits".

2. All staff at Headquarters and the staff of United Nations information centres, the International Criminal Tribunal for Rwanda and field missions and personnel administered by the Department of Economic and Social Affairs and the Office for the Coordination of Humanitarian Affairs at Headquarters with a dependant recognized by the United Nations must review their entitlements to dependency benefits as described herein.

3. All other offices away from Headquarters will be responsible for reviewing dependency claims for their own staff and for submitting copies of the relevant information circulars to the Office of Human Resources Management.

4. The electronic dependency questionnaire (e-P.84) in Inspira will contain the information currently recorded for each staff member and his or her dependants in the Integrated Management Information System. Staff members are requested to review that information carefully, make any necessary changes or corrections and certify the accuracy of the information contained in the form, including the question regarding the amount of dependency benefit in the form of a government grant received for each child.

* The present circular will be in effect until further notice.

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I. Submission of claims using the electronic dependency questionnaire (e-P.84)

5. Staff members will receive e-mail instructions from the Office of Human Resources Management on how to access their dependency questionnaire in Inspira (at inspira.un.org).

6. Upon receipt of the instructions, staff members who have a dependant recognized by the United Nations shall review their dependency data for 2014 in Inspira and electronically submit proposed changes to the Office using the electronic dependency questionnaire (e-P.84).

II. Submission of claims for 2015 and retroactive submission of claims for 2014

7. In accordance with staff rule 3.17, a staff member who has not been receiving an allowance, grant or other payment to which he or she is entitled shall not receive retroactively such allowance, grant or payment unless the staff member has made a written claim within one year following the date on which the staff member would have been entitled to the initial payment. In this regard, staff members wishing to add dependants for 2014 and/or 2015 may do so by submitting the required original supporting documentation, such as a birth or adoption certificate, to the section that services their area in the Human Resources Service of the Office of Human Resources Management. Upon review and verification, the original documentation shall be returned to the staff member. For more details on the required supporting documents or documentation for continuance of the benefit, see annex III.

III. Supporting documentation

8. **Documentation not required**. No documentation is required for a staff member to continue to receive dependency benefits for the following dependants: an unemployed spouse, a dependent child under the age of 18 residing with the staff member and not receiving dependency benefit in the form of a government grant, or a secondary dependant residing with the staff member on a full-time basis.

9. **Documentation required**. To verify a staff member's entitlement to dependency benefits, and to establish his or her continued entitlements to such dependency benefits, documentation in support of the entitlement is required from the staff member for the following dependants: an employed spouse, a child under the age of 18 not residing with the staff member, a child receiving a government grant, a child between the ages of 18 and 21 and a secondary dependant not residing with the staff member. See annex III to the present circular for a summary of the documentation required in support of a staff member's entitlement to dependency benefits.

10. **Obligation to retain original documentation**. Staff members must retain all required original documentation in support of an entitlement to dependency benefits for a period of five years and must be ready to provide that documentation to the Office of Human Resources Management or the Office of Internal Oversight Services upon request, within 30 days for monitoring purposes (see annex III).

Failure to do so will result in the immediate recovery of moneys and the discontinuation of benefits and could result in disciplinary action.

11. Staff members are required to submit the necessary documentation in support of an entitlement to dependency benefits to the contact location identified in annex II. Partial documentation is not acceptable and may result in the immediate recovery of moneys and the discontinuation of benefits, and could result in disciplinary action.

12. When it is necessary for evidence of support payments to be submitted, the following will be considered as acceptable proof: cancelled cheques, money-order receipts, wire-transfer receipts and original records of bank transactions, including printouts of online bank-transfer receipts. Cash transactions are not considered to be acceptable proof of support.

13. The submission of forged documents, the making of a false certification of the information contained in form e-P.84 or a misrepresentation of facts relating to a claim for dependency benefits may lead to the initiation of a disciplinary process and the imposition of disciplinary measures.

IV. Deadline for submission

14. The e-P.84 forms should be submitted as soon as possible, but no later than 30 June 2015. Dependency benefits will be discontinued and overpayment recovered in accordance with section 3 of administrative instruction ST/AI/2009/1 when a staff member does not submit the e-P.84 form and any requisite documentation by 30 June 2015. Before the recovery of any overpayment, staff members will be advised in writing of the decision to recover the overpayment and of the reasons therefor. Recovery will be made through deductions of 20 per cent of the staff member's net monthly salary (excluding United Nations Federal Credit Union deductions) until such time as the full amount is recovered. In instances where the duration of the staff member's contract does not allow for a deduction at as low a rate as 20 per cent, the overpayment will be deducted at a monthly rate that is sufficient to recover the full amount by the expiration date of the contract.

15. Staff members are reminded that, in addition to discontinuation of dependency benefits, non-compliance with the submission deadline may also result in a determination that the claimed individuals are no longer dependants, which could have an impact on the continuation of other benefits, including the G-4 visa, education grant, education grant travel and home leave travel. It is therefore imperative that staff members complete the e-P.84 by the deadline set out in paragraph 14.

Annex I

Types of dependency benefits

1. Staff members in the General Service and related categories may receive a dependency allowance for each recognized primary dependant, who may be a spouse or a child or children. The amounts are set out in the local salary scales, which are established for every duty station and are periodically revised.

2. Staff members in the Professional and higher categories and in the Field Service category will be paid salary at the dependency rate for the first recognized primary dependant, who may be a spouse or a child. A dependency allowance will be paid for each additional primary dependent child at the rates approved by the General Assembly.

3. The conditions for the recognition of a dependency benefit on account of a spouse, child or children or secondary dependant of the staff member are set out in paragraph (a) of staff rule 3.6 and in administrative instruction ST/AI/2011/5.

Dependent spouse

4. A spouse will be recognized as a dependant when his or her gross occupational earnings, if any, do not exceed the limit established for this purpose as set out in staff rule 3.6 (a) (i) and in administrative instruction ST/AI/2011/5, sections 2.1 to 2.7, for a particular calendar year.

5. For staff members in the General Service and related categories and the National Professional Officer category, the earnings limit is the lowest entry level of the United Nations General Service gross salary scale in force on 1 January of the year concerned for the closest United Nations duty station in the country of the spouse's place of work.

6. For staff members in the Professional and higher categories and staff members in the Field Service category, the earnings limit for the spouse's annual gross occupational earnings is the higher of:

(i) The lowest entry level of the United Nations General Service gross salary scale in force on 1 January of the year concerned for the closest United Nations duty station in the country of the spouse's place of work; or

(ii) The gross salary for the lowest entry level in force on 1 January of the year concerned at the base of the salary system (G-2, step I, for New York).

7. In New York, the earnings limit for 2014 was $42,804 (gross salary in effect on 1 January 2014 for a staff member at the G-2, step I, level).

Dependent child or children

8. The conditions for the recognition of a dependency benefit on account of a child or children of the staff member are set out in staff rule 3.6 (a) (ii-iv) and administrative instruction ST/AI/2011/5, section 3. Dependency benefits on account of children with a disability will be paid in accordance with the provisions of administrative instruction ST/AI/2011/5, section 4.

Secondary dependants

9. The conditions for the recognition of a dependency benefit on account of a secondary dependant of the staff member are set out in staff rule 3.6 (a) (v) and administrative instruction ST/AI/2011/5, section 5. When a secondary dependant is recognized, a benefit will be paid at the rate determined by the General Assembly for staff in the Professional and higher categories and in the Field Service category. For staff in the General Service and related categories in New York, the allowance will be paid in the amount set out in the local salary scales, as periodically revised, that are established for each duty station.

Annex II

Contact locations

Staff members administered by Headquarters

Staff members administered by Headquarters who wish to apply for dependency benefits for the first time, who are required to submit documentation in support of an entitlement to dependency benefits for 2014 or who have any questions regarding dependency benefits or form e-P.84 should contact their respective human resources assistant, designated for each Section listed below, by telephone or e-mail (if you do not know who your human resources assistant is, please use the "Contact us" link in Inspira (https://careers.un.org/support.aspx?Language=en-us)) or go to the following location: Human Resources Service, 304 East 45th Street, 6th Floor, New York.

Section I

Department of Management

Department of Safety and Security

Department of Public Information (including for all information centres)

United Nations Fund for International Partnerships

United Nations Democracy Fund

International Civil Service Commission

Counter-Terrorism Committee Executive Directorate

Section II

Department of Peacekeeping Operations

Department of Field Support

Office for the Coordination of Humanitarian Affairs

Department of Political Affairs

Office of the Special Representative of the Secretary-General on Sexual Violence in Conflict

Executive Office of the Secretary-General

Peacebuilding Support Office

Office of the Special Representative of the Secretary-General for Children and Armed Conflict

Office for Disarmament Affairs

Regional Commissions New York Office

Section III

Department for General Assembly and Conference Management

Office of Legal Affairs

United Nations Joint Staff Pension Fund

Office of Internal Oversight Services

Department of Economic and Social Affairs

Office of the Special Adviser on Africa

Office of the High Representative for the Least Developed Countries, Landlocked Developing Countries and Small Island Developing States

Office of Rule of Law and Security Institutions

International Criminal Tribunal for Rwanda

Staff members in field missions

Staff members in United Nations field missions who wish to apply for dependency benefits for the first time, who are required to submit documentation in support of an entitlement to dependency benefits for 2014 or who have any questions regarding dependency benefits or form e-P.84 should contact the Chief Human Resources Officer or equivalent at their respective missions.

Staff members and personnel in other offices

Staff members in the International Criminal Tribunal for Rwanda and liaison offices should contact the human resources office in the respective location.

Associate Expert Programme and other personnel administered by the Capacity Development Office, Department of Economic and Social Affairs, should contact Human Resources Management, Capacity Development Office/Department of Economic and Social Affairs (One United Nations Plaza (DC1), 25th Floor, New York).

For all technical inquiries about using form e-P.84 in Inspira, please use the "Contact us" link in Inspira (https://careers.un.org/support.aspx?Language=en-us).

Annex III

Required documentation for dependency benefits

The following table summarizes the documentation required as evidence of a staff member's entitlement to dependency benefits for 2014.

1. For a spouse with no occupational earnings and claimed as a dependant	No additional documentation is required. However, the staff member will be required to certify that the spouse was unemployed for the period under review (2014).
2. For a spouse with occupational earnings and claimed as a dependant	Proof of gross occupational earnings: all W-2 forms, tax returns or original statements of earnings from all the spouse's employers.
3. For every child claimed as a dependant	An original birth certificate must be presented when the child is claimed as a dependant for the first time.
4. If in receipt of the allowance, for a child under the age of 18 residing with the staff member	No additional documentation is required.
5. For a child (natural or legally adopted) not residing with the staff member or with the other parent (except as provided in number 6, below)	Proof of all payments made directly to the child or to his/her legal guardian for the required amount during 2014, in the form of cancelled cheques, money-order or wire-transfer receipts or records of bank transactions. The amount of support should be at least equal to the amount of the dependency benefit received from the Organization. In addition, in the case of minor children, a notarized affidavit from the legal guardian must be provided attesting to the legal guardianship of the child, that the child resides with him/her and that the staff member is providing continuous support for the upkeep of the child. Cash transactions are not considered acceptable proof of support, nor any payment made to or through a third party.
6. For a child of a staff member who is not the custodial parent or who has joint custody of the child	The original or certified copy of the divorce decree or other court document specifying the amount of child support to be paid by the staff member, plus proof of payment in the year concerned in the form of cancelled cheques, money-order or wire-transfer receipts or records of bank transactions. Cash transactions are not considered acceptable proof of support, nor any payment made to or through a third party. The amount of payment should be at least the amount of the court-ordered child support, or the amount of the child dependency benefit received from the Organization, whichever is higher. In the absence of a court document, an original notarized affidavit from the custodial parent must be provided attesting that the staff member provided continuing support and specifying the amounts paid during 2014, together with the proof of payment described in the initial paragraph.

7. For a child between the ages of 18 and 21[a]	Staff members who were not in receipt of an education grant should submit an original completed form P.41/B (certificate of school attendance) for the school years 2013/14 and 2014/15. Where the school year coincides with the calendar year, form P.41/B should be submitted for 2014. No additional documentation for proof of full-time school attendance is required for a child for whom the staff member received an education grant for the academic years 2013/14 and 2014/15.
8. For a child of a staff member who is in receipt of a government grant	Original government assistance documents reflecting the amounts received each year.
9. For a secondary dependant who resides with the staff member	Staff member's certification of support provided on form e-P.84.
10. For a secondary dependant who did not reside with the staff member[b]	Proof of all payments made directly to the secondary dependant for the required amount during 2014, in the form of cancelled cheques, money-order or wire-transfer receipts or records of bank transactions. Cash transactions are not considered acceptable proof of support. The secondary dependant must be reflected as the recipient on all proof of payment. The staff member must provide one half or more of the dependant's support and, in any case, at least twice the amount of the dependency allowance.

[a] Dependency status is recognized through a period of vacation between school years when the child enrols for full-time attendance during the regular school year. Otherwise, the dependency status ceases as at the last day of full-time attendance at the educational institution. The required forms are available on iSeek under Quick Links/Forms/Allowances and Benefits or from the Executive or Administrative Offices at Headquarters and local Personnel Offices.

[b] At the time of establishment of an entitlement to a benefit for a secondary dependant, staff members should submit in person their own birth certificate as well as the birth certificate or passport of the secondary dependant, with an original, complete form P.85 and proof of support as stated above. Please note that the birth certificates and/or passport must be original or certified true copies.